Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 21^{Day} Jan. 201T 4:30 P M Physician/ Charles Richard Gist Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Lutheran Village Healthcare Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Ye Jan II If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 5 m 2 □ F 85 Director 219-20-0449 Usual Residence of Deceder 10d. Inside City Limits 28a-f shov 10b. County 10c. City. Town or Location frem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 I No Carroll Westminster MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21158 200 St. Luke Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) Brothers Concrete life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Contractors Business Co-Owner 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve ၀ Josephine Rickell Charles Hammond Gist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3508 Sykesville Road, Westminster, MD Joann Brothers Gist/wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Westminster, MD 1/25/2011 4 Donation 5 Other (Specify) Deer Park Cemetery 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licensee 412 Washington Road, Westminster, MD M. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death is certificate has been signed by the director, page 2 should be detached Unknown g Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not res þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 26. Place of Death (Check only one) Division of Vital Be 25. Was case referred to medical Hospital: Other Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral dir 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a WJL 10 ame and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

filed (Month, Day,

JAN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🌖 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1:15 P M Physician/ GELINAS BEATRICE 01 8 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD GENERAL CITY HOWARD COUNTY HOSP ELLICOTT TAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🔀 F Months Days Hours Min. 95 Canada 003-07-7082 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at the Maryland Director 1 X Yes 2 No MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 72 hours after death with 21043 USA 3004 North Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 Nidowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Tailoring Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Halle Archille Duquette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heaith ar Important: If item 27 is any injury or other trau 6108 Holly Ridge Court Columbia, MD 21044 Donald Gelinas/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Baftimore Washington Crematory 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/21/2011 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home Signature of Johneral Service Li 1 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final ysician SEPSIS WITH URINARY TRACT INFECTION SEVERE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner URINARY TRACT INFECTION AND CARDID PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami STAPHYLOCOCCUS METHICILLIN RESISTANT Cause (Disease or liniury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical DEMENTIA, DEPRESSION CORDNARY ARTERY that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) Pregnant at time of death ed by the a g 🔲 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 has page 2 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; to 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ᅆ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) monm 18/204 D74114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

CHARU

31. Date filed (Month, Day, Year)

JAN20

NANDA MD

32. Registrar's Signature

5755 Cedar Ln Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Month 27 2011 11 / M Newton Henry Gales Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral X**□ M 2 □ F Days Virgina 8925437 79 578-40-4391 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director 1 X Yes 2 No Lanham Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 22706 8902 91 St.Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If **X**es, Give Year or Dates. 2 Specklack Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation

16a. bind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) D.C.General Painter Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 Annie Bernice Tyler William Gales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 4833 Cavallo Way Woodbridge, Va. Brenda Lane -Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3★ Removal from State 4 □ Donation 5 □ Other (Specify) Bethel Baptist Ch 2/5/2011 Amissville, Va 21. Signature of Funeral Service Lide 22. Name and Address of Facility Will. Thompson Funeral Home 503-7 North Main. Thompson Funeral Home 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List one cause on each line Immediate Cause (Final disease or condition Physicianz) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last attending physician and I for use as the burial-tran Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death ed by the a g 🗌 Unknown P.O. signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 X No prior to completion of cause of certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🛮 Natural 5 Pending 1 Yes 2 No death. M 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

31. Date filed (Month, Day, Year) JAN 3 1 2011

MO

29b. Signature and title of certific

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

GREENBELT MARILAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Jan. 25 2011 Francis Hardy 7:15 ₺ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2612 Dawson Avenue Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) June 30, 1915 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Days Hours Director 220-26-6867 95 June MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Silv<u>er Spring</u> MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2612 Dawson Avenue 20902 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc ō ģ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates. 1940 – 45 1 Yes 2 X No Specify. Specify: Wh ite "natural" 3 ₩ Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 8 Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F John Francis Hardy injury or other traumatic Susannah Surratt Defmit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 20906 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Hardy/Daughter 14320 Long Green Drive, Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/29/11 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Ft. Lincoln Cemetery Brentwood, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc DuduM Spring, MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death ₽nysician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Alzheimer's Disease Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate and I-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical that the death certificate be the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy ó in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed Atherosclerotic Peripheral Vascular Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: Aft To the Funeral Direction of the Completed filled in by the

Medical

Registrar

31. Date filed (Month, Day, Year)

and title of certifier

JAN 27

29a. Certifier

29b. Signat

only ong



💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D12121

29d. Date signed (Month, Day, Year)

Jan.

25,

2011

20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:20P Evelyn Elizabeth Hall January 16 Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Prince George Clinton 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 M 2 X 12/16/1934 76 Director 108-24-7030 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Prince George Upper Marlboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4709 Cashill Court 20772 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates and 2 should be filed within 72 hours Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical Is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norwood Harmon Elizabeth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Glenwood Ave., Yonkers, New York 10701 Jane K. Thomas/Sister item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosehill Cemetery 1/24/2011 Linden, New Jersey 21. Signatur & Funeral Service Ligense 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. 4 (1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Farline Immediate Cause (Final disease or condition 6000 Physician Medical resulting in death) Due to (or as a ansequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last ng physician and as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy ò in the past 12 months? Month Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant condition 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 2 No 1 Department 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and Atle

31. Date filed (Month, Day, Year)

JAN 2 0 2011

who completed cause of death (Item 23a) (Type, Print)

MD

DUO 5 5/20

1328 jonthem kverm St Suck 310 Washin

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jo / 7:06 P M Parker Jeffers Frances Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 808 College Lane, Apt. Wicomcio Salisbury 8. Date of Birth (Month, Day, Year) 8-24-1916 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 □ M 2 💢 F Months Director 214-10-9544 94 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😿 No MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 808 College Lane, Apt. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 12 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Roxie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fulton P. Jeffers - Son 23278 Grey Drive, Onancock, Virginia 23417 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department 4 Donation 5 Other (Specify) Parsons Cemetery 1-29-2011 Salisbury, Maryland 22. Name and Address of Facility Bounds Funeral Home 705E. Main Street Salisbury, Maryland 21804 . Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final CARRBROVASCULAR Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been siy completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 Residence 6 \(\text{Other (Specify,} \) E No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SARAH GLADYS JOHNSON JANUARY 2011 6:59 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Country) MARYLAND 1 🗆 M 2 🗓 F Hours OCT 30, Year) 218-26-4604 81 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND HARFORD 1 ▼ Yes 2 □ No HAVRE DE GRACE 10e. Street and Number 10f. Zip Code items 23a or 10g, Citizen of What Country? Funeral 816 N. JUNIATA STREET 21078 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: BLACK 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NURSE TECHNICIAN VA HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VALLEE RICE HELEN HILL 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac HARRY D. JOHNSON / HUSBAND 816 N. JUNIATA STREET, HAVRE DE GRACE, MD 21078 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CLARKS UNITED METH 02/05/11 4 Donation 5 Other (Specify) BEL AIR, MARYLAND Signature of Funeral Service Licenses Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Artun Disease Immediate Cause (Final Gromany Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 9 Unknown been signed by t should be detach Part II. Other significant conditions of Chy. Rual mibuting to death but not resulting in the unde<u>riving</u> cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of cate has t autops, performed? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 읃 2 No 1 Inpatient 2 PER/Outpatient 3 IDOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner To the best of my knowledge, death occurred at the time date and place, and due to the ea 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 28/11 Mans -609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1106 Revolution St Milbam Ho Kemphioling 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Johns phonzo Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial 16 astor Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 8. Date of Birth **Funeral** Min. Year, Months Hours (Month, Day, 49 Yrs 220-78-5563 19 Maryland Director Usual Residence of Decedent f show 10d. Inside City Limits 10b. County 10c. City. Town or Location of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland Director Trappe 1 ☐ Yes 2X No Talbot MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21573 Funeral United States 2835 Money Make Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by Black 1 Yes 2 XNo Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Car Wash Detailing Autos Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ၉ Geraldine E. Johns Avon Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2835 Money Make Rd., Trappe, MD Herbert Rl Wilson/Stepfather 21673 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o þ 1XXBurial 2 Cremation 3 Removal from State Easton, Maryland Spring Hill Cemetery 01/29/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 Signature of Funeral Service Licensee Michael Esken +-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 months Physician/ Pulmonary disease or condition resulting in death) Medical Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 4 EAMS 1 h con Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Pregnant at time of death 2 No s been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Records, 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of page 2 s has 1 Yes 2 No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending work 1 Yes 2 No death. ithin 24 hours after death.

the Funeral Director: At ampleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Sgnature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 17, 2017 9:55 Veronica Reene Kitchen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Upper Marlboro 5423 Thomas Sim Lee Terrace . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs, last birthday, 8. Date of Birth **Funeral** Days 1 □ M 2 🔀 F OCt. 1, 1961 Months Hours **Director** 200-48-9190 Pennsylvania Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro Prince George's 1X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 USA 5423 Thomas Sim Lee Terrace 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏝 No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic Elementary/Seconday (0-12) College (1-4_or 5+) C.P.A. U.S. Dept. of H.U.D. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Kitchen Shirley Feu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Kitchen / Mother 2142 N. 12th St., Philadelphia, PA 19122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ivy Hill Crematory 1/24/2011 4 Donation 5 Other (Specify) |Philadelphia, PA 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy., Bowie, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fetiture. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Pnysician/ Steatosis of Liver disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Alcohol Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 2 No Yes the detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed has certificate 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 😾 Residence 6 Other (Specify) 1 Tes 2X No 유 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar 29b. Signature and title of certifier

Jacob,

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

M.D

29c. License numbe

D0059633

1221 Mercantile Lane, LArgo, MD

29d. Date signed (Month, Day, Year)

1/18/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ludmilla D. Kucher Physician/ January 18, 2011 6:41 P Medical 4a. Facility Name (if not institution, give street and number)
2847 Carrollton Road 4b. City, Town, or Location of Death Annapolis 4c. County of Death
Anne Arundel **Examiner** Social Security Number last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 029-12-5670 Months March 8, Year New York 1 🗆 M 2 🔀 F 87 Days Hours **Director** Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 2847 Carrollton Road 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 XXIVo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Yes Give White XX Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary U.S. Naval Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anthony Diachenko Vera Lensky 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 167 Deale Road Tracy's Landing, Maryland Vera Karelian/daughter 20779 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore Crematory : 1/20/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 00 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vascular ereba disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician the dria shed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Pyactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last 657 PM Ye ar Month **Physician** 2011 7 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1119 Pemberton Lane Lothian 8. Date of Birth (Month, Day, Year) 02/19/1950 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
 Country) **Funeral** Min Hours Months Days North Carolina 1 □ M 2 😾 F 239-88-9900 60 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Director MD Lothian Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1119 Pemberton Lane 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Black. þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Internal Revenue Ser. Program System Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gilbert Hill Carlene Hill ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1119 Pemberton Ln, Lothian, MD 20711 George Knight (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/22/2011 4 □ Donation 5 □ Other (Specify) Locust Grove Big Cr. Westfield, NC 22. Name and Address of Facility Hardesty Funeral Home P.A. 21. Signature of Funeral Service L 77 ø Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cancer years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 24☐ No 24a. Was an certificate has birector, page 2 s autopsy perform 1 □Yes 2. No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 \(\text{Nursing Home} \) Sesidence \(6 \) Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 64379 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Sule 210 (3) } 31. Date filed (Month, Pay2 Year) 2011

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year 0030 M Mary Doreen Loftus **Physician** January 28 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton Hospita Memorial 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Washington, DC 1 □ M 2 🕅 F 579-48-2334 77 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at Federalsburg 1 XYes 2 ☐ No Caroline MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~~ any injury or other traumatic event. United States 305 Buena Vista 21632 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. White 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: If Yes, Give Year or Dates: 2 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clerical College (1-4or 5+) Elementary/Secondary (0-12) Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doretha Isabel Clarke Bevis McGuire Bowles ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 306 N. Main St., Federalsburg, MD 21632 Mani Guesfeird/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Anatomy Board Date 20a. Method of Disposition 01/29/11 Baltimore, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏ Conation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Maryland Anatomy Board 655 W. Baltimore St., Baltimore, MD 21201 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hours **Physician** disease or condition resulting in death) un /Medical Due to (or as a consequence of Carcinoma all Examiner mous oropharung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending a benefit of the Funeral Director. attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2. 1 No 1 □Yes 2 NO 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined filled in by 4 Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 05

State Registrar 31. Date filed (Month, Day,

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South Washington

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year) A 30 Da

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32. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Agnes Parsons Leach PM Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 132 Carolyn Ave. Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F 0472071908 Maryland Director 102 212-10-0221 Usual Residence of Decedent در is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits death with the Maryland Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 132 Carolyn Ave. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hyglene. item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) service assistant telephone company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George H. Parsons Bertie E. Pryor 19a. Informant's Name/Relationship (Type, Print) ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Rd•, Allen, MD 21810 Mary Lentz/great-niece permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/29/2011 Parsons Cemetery Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use (Disease or imjur and that initiated events resulting in death) Last Due to (or as a consequence of) as the burialattending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Year the be detached g 🗌 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law page 2 s has performed certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 desidence 6 Other (Specify, 2 **N**o မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending within 24 hours after death To the Funeral Director: A completed filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. M dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) reliving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Stonature of certifier 29c. License number 000 of person who completed cause of death (Item 23a) (Type, Print) 31413 WINTERRAG IK STITE W3 SAUBBUMY WIS ZIECH GITTOZMAN W JAN 26 State

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Registrar

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Funeral	7	5. Social Security Number	6. Sex		7. Age (in yr	s. last birthday)	If Under 1	Year	If Under 24H	rs. 8. Date of 8	Birth (MM/DD/YYY			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumantic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Related Mercine M. M			star	40					umber, City or To a.c.h., MD	wn, State 207		
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Baltimore, permit. Pages I ar Department of He Important: If ite		1 X Burial 2 Crem 4 Donation 5 Other		Removal fro		crematory or ot o. Memor		rde	ns 01-	-28-201 ⁻	l Dunki	rk.	MD	
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Division pital or Attendir ours after death. teral Director: A filled in by the fu	Certification:		Could not be determined	(Specify)	e of Injury - A	t home, farm, stre	et, factory, of	rice bui	lding, etc.	or Town,		ber of Ru	ıral Route Number, City	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician property little in by the funeral director, page 2 should be detached for use as the bear of the funeral director, page 2 should be detached for use as the bear of the funeral director, page 2 should be detached for use as the bear of the funeral director, page 2 should be detached for use as the bear of the funeral director, page 2 should be detached for use as the bear of the funeral director, page 2 should be detached for use as the bear of the funeral director, page 2 should be detached for use as the bear of the funeral director.		4 Homicide 29a Certifier 1 Certifylr	o Physician:		t of my knowl	edge, death occu	rred at the tim	ne. date	and place, ar	d due to the ca	use(s) and mann	er as stat	ed.	
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00635 State of Maryland / Department of Health and Mental Hygiene William McDaniel, Jr. 1- For State Certificate of Death Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 22, 2011 0250 hrs Medical Examiner William McDaniel, 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Davs Country) DC Director 3/11/1954 577-76-0469 1 XM 2 F 56 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1X Yes 2 No Hyattsville Prince Georges Director 10g. Citizen of What Country? 10e Street and Number 20781 USA 3924 Madison St. 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 X Married 2X No 1 Yes Specify: Black 1 Yes 2 No specify: If Yes, Give Year 3 Widowed 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-UU30
permit. Pages I and 2 should be filed within 72 hours.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nation injury or other traumatic event, the Medical Exp Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service 12th Chef Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Willie McDaniel, Mary D. <u>Beatty</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3924 Madison St. Hyattsville,MD Linda Ellis/Wife 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2/5/2011 Riverdale, MD Riverdale Park 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc 3831 Georgia Ave. NW Washington, DC 2001 cc0278 23a. Part I. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Hypertensive Atherosclerotic Cardiovascular Diseas e Between Onset and Complicated by Hypothermia failure. List nly one cause on each line /Medical Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED 23a, 27, 28a-f per me g913 3-2-11 vt the attending physician and for use as the burial -**X** UNPENDED Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy dent pregnant in the 2 Fetal death Month Dav Live birth 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed 2 No 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) of Vital or Attending Physician: Hospital: 1 Inpatient 2 ER/Outpatient 3 🗹 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 27. Manner of Death subject exposed to cold 1 Natural Division 5 Pending fd 2:27am 1 Yes 2 X No fd 1-22-11 death. environment the 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State). 3924 Madison Street Hyattsville, Md. 20782 in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 6 Could not be Suicide determined (Specify) driveway Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 54 cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

PEND

31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001 OCME 2006

29b. Signature and title of certifier

Theodore M. King, Jr., MD

FFR 07 2011

ORIGINAL

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 24, 2011

and manner stated

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 27 / 2011 Stephen Demetrick Matthews 7:26 a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 3102 Gideon Ct. Charles Waldorf Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Country Germany Days Hours 1 🔀 M 2 🗆 F 037157 218-21-7018 7975 Director Usual Residence of Deceden "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director ty Yes 2 ☐ No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3102 Gideon Court 20602 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No 1995 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates. 2005 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Dept. Of Navy Elementary/Seconday (0-12) 12th College (1-4 or 5+) Federal Government Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed h and Mental H 7 is marked ot Charles Matthews Ginger Milstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Shalita Matthews/wife 3102 Gideon Ct. Waldorf, MD 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State MD Veteran Cem. 02/8/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signaturé of Funeral Service Licensee 2294 Old Washington Rd Waldorf, MD 20601 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Shu disease or condition (-Vn Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be entited thours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 2 X director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{X Residence} \) 6 \(\text{Other (Specify)} \) 2 🗌 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 Pending injury work? 126 AM 1-27-2011 Accident Investigation 3 Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3167 GKPCK + 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Howe Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completed fil 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-28-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7.135H 11655 WINESUP Plaplatu MO 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

11-00825 Donald Markward Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Donald Markward	1- For State Registrar	State	of Marylar	-	rtment of <i>tificate of</i>		d Mental F		2011 eg. No.	0 4 0 1 7		
Physician/ Medical Examiner	1. Decedent's Nam	e (First, Middle,La		l P. Mar	kward			2. Date of Dea Month January 2	Day Year	3. Time of Death 0400 hrs		
	4a. Facility Name (e street and num	ber)	ľ	•	Location of Deat		4c. County of Death			
Funeral	Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of B									Baltimore City irth(MM/DD/YYYY) 9. Birthplace (State or		
Director	184-30-06	558 ¹ X	M 2 F	72	Yrs	Months Day	s Hours Mi	01/19/	1939 Foreig	on untry) PA		
any	Usual Residence of 10a. State	f Decedent 10b. County		10c. City,	Town or Locati	on				10d. Inside City Limits		
	PA Chester Cochranville								000000000000000000000000000000000000000	1 Yes 2 No		
the Maryland or 28a-f sh	10e. Street and Nu	_{mber} etwater P	ath			10f. Zip Code 1933()		og. Citizen of What Cou			
er death with the Maryland or items 23a or 28a-f show remust be notified at once. Funeral Director		ed 2 X Married		dent Ever in U.S			spanic Origin? (S	- 14. Race - Amer White, etc.	ican Indian, Black,			
fter deat			1 X Yes	2 No 5-70	1	Yes 2 No	specify:		Specify: Whi	te		
5-0036 ed within 72 hours afti tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's E	ducation (Specify o	nly highest grade				ation (Give kind of e. DO NOT use re		16b. Kind of Business/Industry			
036 ithin 72 ne. r than 'fedical	Elementary/Sec		4	¥ 01 3+)	Purch	asing Ma			Stee1			
215-0 be filed w ntal Hygie rived othe cent, the N		(First, Middle, Last Donald L		ırd				ne (First, Middle, I J. Cheek	Maiden Surname)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Na	ame/Relationship (-					ille, PA 19			
e, MI and 2 s Health a item 27	20a. Method of Dis	position		20b. P	lace of Dispos	ition (Name of ce		Date	20c. Location - City or			
Baltimore, bermit. Pages 1 ar Department of Hee Important: If ite	(32)	Other Specify	_		rematory or oth en Run	Cemeter	y Fe	b.5,2011	Atglen, PA	1		
Balti permit. Departr Import injury	21. Signature of Fu	ineral Service Lice	7		22. N	ame and Addres	s of Facility hmu~> 1	Ed Wed	erk DE 19	702		
Physician	23a. Part I. Enter the failure. List or	ne disease, or com nly one cause on e	olications that car ach line.	used the death.	Do not enter th	ne mode of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and		
/Medical examiner	Immediate Cause or condition resulti		Comp Due to (or as a c			rostate	ctomy			Death		
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50, te be executed sysician and burial - transi				23a, b, Z utcome of pregn		ne g914	4-15-11	Vt	23d. Date of deliver	<u> </u>		
Sox 6876(death certificate e attending phy. I for use as the b	IF FEMALE: 23b Was decedent past 12 month:		1 Live bir		2 Fe	tal death 3	Ectopic pregr	nancy		Day Year		
	1 Yes 2		9 Unknov	vn	3 Oi	her (Specify)						
. 4 .4 0	1	ificant conditions	contributing to	death but not re	sulting in the ι	inderlying cause	given in Part I.		obacco use contribute to s 2 No 3 Pro	the cause of death? bably 4 Unknown		
Division of Vital Records, P.O. rat or Attending Physician: The law requires that trs after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deace entification: To Be Completed by F		<u> </u>	•					24a. Was autop	osy prior to	utopsy findings available completion of cause of		
Recoi The law icate has page 2 sl								1 ✓ Yes	rmed? death? 2 No 1 ✓ Y	es 2 No		
Vital Rechysician: The this certificate al director, page	examiner?		Hospital: 1 🗸 In	patient 2	ER/Outpatient		Other Nurs		Residence 6 Othe	r:		
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rision r Attencer death irector: n by the	2 Accident	5 Pending Investigated Could not	28e Place	of Injury - At ho	me, farm, stree	et, factory, office			Street and Number or Ru	ural Route Number, City		
Division or Hospital or Attending 24 hours after death. Funeral Director: Afte rely filled in by the funeral al Certification:	3 Suicide 4 Homicide 29a. Certifier	determine	(Specify)					or Town, S				
Division of Vital 1 To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be ((Check only one) 2		ian: To the best r:On the basis of and manner sta	examination ar	e, death occur nd/or investigat	red at the time, o tion, in my opinio	date and place, ar n, death occurred	nd due to the caused at the time, date	se(s) and manner as stated and place, and due to the	ne cause(s)		
A S H S A	29b. Signature and	title of certifier	and mention Sta				se number		29d. Date signed (Mo			
	30. Name and add	ress of person who	completed cause	e of death (Item	 23a)		.141		34,134,7 30, 201			
5	Donna M. \	/incenti, MD	Assistant M	edical Exam	iner 900		e Street, Balt	imore, MD 21	223			
State Registrar		EB 02 2)11 32 Reg	gistrar's Signatu	y. Spa	Ky						

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	State of Maryland	/ Department of H	eann and wer	itai nvuleik

Robert Milton Neal	1	- For State	State	of Maryla		artment o	f Health an f Death	d Menta	al Hygiene	Reg. No		
Physician Medical Examine	7		e (First, Middle,Last			~			2. Date of I Month Januar	Death Day	Year	3. Time of Death 2325 hrs
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Funeral		2439 Fairm 5. Social Security N		х	7. Age (In yrs, I	ast birthday)	Hampstead If Under 1 Yea		24Hrs. 8. Date o			Birthplace (State or
Director		214-64-9	265	M 2_F	56	Yrs	Months Day	s Hours	Min. 2/17	/195		reign Country) MD.
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Research of the Maryland of the than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Finneral Director	- miciai		ed 2 Married	Armed Fo	2 🔀 No	lf Y	es, specify Cuba	n, Mexican, P	n? (Specify Yes or Puerto Rican, etc.)	No-	White, etc	
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5-00; led with Hygiene other t	3	17. Father's Name	(First, Middle, Last)		1 0	water	loabe wor	18.Mother's	Name (First, Midd	le, Maide	n Surname)	
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more, Pages lar nent of Hee aut: If ite			Cremation 3 Other Specify:	Removal fro	om State	crematory or of			Jan 28, 201			
Balt permit. Departi Import injury		21. Signature of Fu	neral Service Licen	see	M00741		Name and Addres		Eline F		al Home	
Physician Medical		failure. List on	ne disease, or comp ly one cause on ea	ch line.	aused the death	n. Do not enter t	the mode of dying	, such as car	diac or respiratory	arrest, s	hock, or heart	Approximate Interval Between Onset and Death
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Division Division To the Hospital or Attent within 24 hours after death within 24 hours after death completely filled in by the filled in by	ē	29a. Certifier 1 (Check only one) 2	Certifying Physici Medical Examiner	On the basis	of examination a							
2		29b. Signature and	I title of certifier	and manner s	stated.			se number				(Month, Day, Year)
WJL		30 Name and add	ress of person who	completed carr	se of death (Item	m 23a)	0.0	.M.E.		Ja	anuary 25, 2	011
1		Ling Li, MD		edical Exa	miner 900	W. Baltimo	ore Street, Ba	Itimore, M	ID 21223			
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			_ FOF	State of Maryland / Department		Mental Hygi	ene	=			
		_	State Registrar	<u>Ce</u>	rtificate of Death	Re 2. Date of Death	g. No.	3. Time of Death			
П	Physicia	an	Decedent's Name (First, Middle, Last) OLA PRINCE	DADWED ID		Month JANUARY	Day Year 27 2011	02:45 PM			
warca	/Medic	al	4a. Facility Name (If not institution, give stre	PARKER, JR.	4b. City, Town, or Location of Death		4c. County of Death				
	Examin	er	ELKTON CARE AND RE		ELKTON		CECIL				
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, NOV . 27,	9. Birthpla Year) Counti	ace (State or Foreign ry)SELMA SIANA			
L	Director		435-12-03/8	1 2□ F 92 Yrs.		NOV. 27,	1918 LOUI	SIANA			
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10	d. Inside City Limits			
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	th the	Director	10e. Street and Number		10f. Zip Code		g. Citizen of What Count				
	ath w	rai	57 PORTER ROAD		21901		JNITED STATE 14. Race - America				
	items items in error	Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Forces? 1 MTYes 2 □ No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, et	tc.			
036	urs af al", or Exem		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give US 1NAVY Year or Dates: 1941-61	1 ☐ Yes 2 📉 No Specify:		Specify: WHIT	E			
5-0	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Modest Exercit or routified at	Completed by	15. Decedent's Educat (Specify only highest grade c	ompleted) (Give	edent's Usual Occupation e kind of work done during most of work		6b. Kind of Business/Indi	ustry			
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Maryland 21215-0036	shou and N is mar	_	19a. Informant's Name/Relationship (Type		ing Address (Street and Number or Ru						
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Ħ	artme ortant Injury		4 Donation 5 Other (Specify) 21. Sign use 2 Service 2 S	CEM	2. Name and Address of Facility CRO		CHERRY HILL, AL HOME, P.A				
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Box 6	nding use as	n/Me	IF FEMALE: 23c. Was decedent pregnant 23c	. If yes, outcome of pregnancy			23d. Date of delive	ery			
	requires that the death certifi been signed by the attending I hould be detached for use as	Physician/Me	in the past 12 months? 1 □Yes 2 □No		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year			
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			31. Date filed (Month, Day, Year)	32. Registrar's Signature							

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 25^{Day} Month Physician/ 201 T Jan. 11:12 A™ BRENDA JOYCE PEGUES Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Oxon Hill 1100 Owens Rd. #310 If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 22676525 1 M 2 TF **,** 1952 58 June Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince Georges Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20745 USA 1100 Owens Road #310 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Specify:Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done of life, DO NOT use retired) during most of working (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ည pe Rutha Raines permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. Horace Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Samuel Parker/Brother 6622 Oak Drive,Alexandria, VA 22306 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill 2/1/2011 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Home any in Franklin St., Alexandria, 22314 23a. Part 1. Enter the disease, or compocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Arterioscleratio Cardiovascular 5yen disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by @ Pulmonary 2 No 3 Probably 4 Unknown 1 Tyes After this certificate has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of page 2 : death? performe 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work' 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Accider☐ Suicide within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature, and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 1-26-2011 D002015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year,

M.D.

32. Registrar's Signature

6492 Landever Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 4:45 AM DOUGLAS E, QUESENBERRY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND MEDICAL CENTER University of BALTIMURE Baltimor . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State **Funeral** Months Days Hours Country) 236-54-6810 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden St ၉ 19a. Informan's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Abrams Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 2-5-2011 . Signature of Funeral Service Licenses 22. Name and Address of Facility Strano Treeley Family Funcial Home 19702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner INFECTION URINARY TRACT Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by gastiointestinal bleed 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Vinerth 100739 29/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201-1595 BACTIMORE MD JASSAL 22 5. Greene

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 Day 201 Year Physician/ Anthony Charles Romano Janh. 4:01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington 11216 Lund Place Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** oct. 14,1922 1X M 2 F Months Davs Hours NY 88 070-18-2328 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director Kensington MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 USA Funeral 11216 Lund Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 x Married Maryland 21215-0036 1 Yes 2x No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates. WWII the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Insurance Broker Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Betrina Guglielmo Sigmond Romano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5301 Hines Road, Frederick, MD 21704 Lisa Romano/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/3^{Date}/11 cemetery, crematory or other place) 1x Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forestery 4 Donation 5 Other (Specify) Owings Mills, 21. Signature of Funeral Service Licenses Trancad Address of Facility ollins Funeral Home 500 University Blvd. W., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sarcoma Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Day 2 No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed certificate 1 Yes 2 No Yes 2 X No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🕇 No Other: 4 Nursing Home **SC**:Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

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3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

WW 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Wallmark, MD 9707 Medical Center Drive, Rockville, MD 20850

M.17

32 Registrar's Signature

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24, 2011

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29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 23, 2011 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	OD (ending ath.	Ęį		ling	r, Day, rear)		1[Yes	2 No						
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 23, 2011 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	ViSi or Att fter de Sirect in by	ij		28e Plac	ce of Injury - At h	nome, farm, stree	et, factory, off	ice buildir	ng, etc.			Rural Route Number, City			
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O.C.M.E. January 23, 2011 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	To th within To th	ledi		and manner s		androi investiga									
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature		2	230. Signature and title of certific	1 /	M										
Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	25		Melin/i	nanel/	rea of doath /lt-	m 23a\									
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State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar			,	Cer	tificate of	Deatl	'n			Re	g. No.			
Physician/		me (First, Midd	le,Last)								ate of Death		Year	3. Time of Death	
ledical Examine		n Paul								Ja	January 16, 2011				
)	4a. Facility Name				•	4			ocation of De	eath					
		Place & Step					Edge		Lati I a	10	Anne Arundel rs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State				
Funeral	5. Social Security		6. Sex		e (In yrs. la	ist birthday)	Month:	r 1 Year Days	If Under 24 Hours	Min			Foreig	n	
Director	213-04-	4958	1×M 2	2 F	28	Yrs.)9/19/	1982	Cot	untry)Wash, DC	
,	Usual Residence				100 City	Town or Locati	on		_	-				10d. Inside City Limits	
w any	10a. State	10b. County	3	11	1		OII							1 Yes 2 X No	
Aaryland 28a-f show Latonce, ector	MD		Arunc	<u>ет </u>	Gallio	mbrills 10f. Zip Code						10g. Citizen of What Country?			
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with the Maryland ms 23a or 28a-f sho be notified at once.								054_			USA		. In East Direct		
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or death	3		1		□X No	No I Yes 2 No specify:							i6.	White	
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5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin	Flementary/Se	condary (0-12)		ollege (1-4 or					OO NOT use					•	
36 nin 72 e. fban dical	<u>.</u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2	Ch	nef					Resta	aurant	S	
d with	17. Father's Nam	e (First, Middle	, Last)			***	-	18	8.Mother's N	lam e (Fir	st, Middle, M	laiden Surna	ame)		
215 be file mtal H rked o ent, th		M. Rad	die						Mado	onna	Norwo	od			
nore, MD 21215-0036 ges 1 and 2 should be filed within 7 gree 1 and 2 should be filed within 7 or 1 filem 27 is marked other than other traumatic event, the Medical To Be Compli		Name/Relations	ship (Type, P	rint)		19b. Mailing	Address	(Street	and Number	or Rural	Route Num	ber, City or	Town, State	Zip Code)	
MD 1 2 sh th and 27 is	Madonna	Brenna	n/Mo	other		_					s, MD				
Te, land Heal	20a. Method of D		. a 🗆 pa	mount from St		Place of Disposi rematory or oth			etery,	Da	ate	20c. Locati	ion - City or	Town, State	
TOI Pages ent of at: I		5 Other S		moval Irom St	ate	Lady o			elds 1	1/22	/2011	Mille	ersvil	lle, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland begarment of Health and Mental Hyghers than "anatural", or items 23a or 28a-fahe important: If item 77 is marked other than "anatural", or items 23a or 28a-fahe injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	21. Signature of		_			22. N	ame and	Address	of Facility I	Beal.	l Fune	eral Ho	ome		
E P P E	6512 NW Crain H										Bow	vie, M	D 207		
Physician					the death.	Do not enter th	ne mode o	of dying, s	uch as cardi	iac or res	piratory arre	est, shock, or	r heart	Approximate Interval Between Onset and	
Medical	failure. List only one cause on each line. Immediate Cause (Final disease a, Drowning and Hypothermia											Death			
_xammer	or condition resu	Iting in death)	Due to	(or as a cons	equence of	·): -									
	Sequentially list		b.	(or as a cons	aguanaa af	٠.									
anice and a series	if any, leading to cause. Enter Un	derlying Cause		(Or as a Corrs	equence or	<i>.</i>									
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ion tendii or: /	1 Natural 2 ✓ Accident		airia	-OUND: Jan_16, 2011		FOUND: 1248 hrs		1 Ye	es 2 🗸 No	·	•				
Division al or Attendi as after death. al Director: /	3 Suicide			28e. Place of li	njury - At ho	ome, farm, stree	et, factory	, office bu	iilding, etc.		or Town, S	tate)		iral Route Number, City	
Division os spital or Attending nours after death. neral Director: After filled in by the function:	4 Homicide	e dete	ermined	(Specify) Po	nd					Riv	erton Pláce	e & Stepne	ys Lane, E	dgewater, MD	
Division of Vital Records, P.O. Box 68: To the Bospital or Attending Physician: The law requires that the death certif within 24 butous after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as indical Certification: To Be Completed by Physician	29a. Certifier (Check only one) 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										ed. e cause(s)				
To the Hos within 24 h To the Fur completely	one) 2	/ Medical Exa	aminer:On u	nanner stated	immation a	nd/or investigat			,		e time, date				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNÜARY 2011 11:30PM PAULINE D. ROSS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 8. Date of Birth
(Month, Day, Year)
SEPT. 13,1944
MARY LAND f Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday Funeral 1 □ M 2 🄀 F Days Hours Min. 220-42-8494 Director 66 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Directo 1 ☐ Yes 2 No MARYLAND CECIL PORT DEPOSIT 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number UNITED STATES 1120 JACOB TOME HIGHWAY 21904 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILEY PERRY SALLIE SHAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL ROSS / SPOUSE 1120 JACOB TOME HIGHWAY, PORT DEPOSIT, MARYLAND21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JANUARY 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or 30, 2011 UNION CEMETERY ELKTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) rvice La isee 21. Sign v e 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Prysician disease or condition resulting in death) orunary mont Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mipleted filled in by the funeral director, page 2 should be detached for use as the burlansit mipleted. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No Yes 2 XNo Division of Vital 25. Was case re erred to medica examiner? 26. Place of Death (Check only one) Be 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 🗌 Yes ျပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury | X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the within 2 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed [M

1 Kton

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 25, 2011 11:50 A.M Sturgess Tda No1a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral Days 1 M 2 X Months Hours 05/13/1922 Tennessee 88 Director 220-34-3446 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No MD Huntingtown Calvert 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 20639 6100 Huntingtown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) clerk/ meat cutter retail grocery Be 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important, If item 27 is marked any injury or other transporce 0 Nettie Mae Brumette Richard Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 Huntingtown Rd., Huntingtown, MD 20639 Nancy Lee King, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Upper Marlboro, MD Trinity Cemetery 01/31/2011 ture of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 20736 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying executed the burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death ed by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? this certificate has performed 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? No 2 Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this d in by the funeral di 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0027189 201 KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAHIR VOUSAF, 2417 Solomons Island Rd. Huntingtown, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23 Day 201 Tea Jan. _**a** M Washington Swett, Jr. Trevor 3:26 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1925 Country) atvia Dec 10, Days Hours Min. 1X X M 2 □ F Yrs. 578-34-1268 Director Usual Residence of Decedent 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and if if item 27 is marked to 4ther than "natural", or items 23a or 28a-f sho and the trans when the there is a mark of the than unity or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Washington DC 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA T399 20015 6200 Oregon Ave. NW, Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. X Yes 2 No Yes, Give 1 O Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 res, Give Year or Dates. 1 9 4 9 - 7 9 White 1 ☐ Yes 2 ☐ No 3 HWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Army 5+ Colonel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marjorie Paret Trevor Washington Swett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8209 Kentbury Drive, Bethesda, MD 20814 Marjorie B. Swett/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date / 24/ permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place)
Metropolitan Crematory 1 🗌 Burial 2 🛣 Cremation 3 🗌 Removal from State Alexandria, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or s a consequence of): Physician/ disease or condition resulting in death) Medical **Examiner** eumoni Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2.X No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2x No မ 1 3 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 29c. License number D63204 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Coyle, MD Road, Pethesda, 8600 Old Georgetown Subwban 128 p. Jal 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State JAN 27 MARKET Registrar

3 26AM

SWETT.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Director Direct	olace (State or Foreign try) NY Od. Inside City Limits 1 Yes 2 XNo otry? ran Indian, etc. t e dustry ring MD 20906 er Spring own, State
A. Facility Name (if not institution, give street and number) A. Facility Name (if not institution, give street	nery place (State or Foreign try) NY Od. Inside City Limits 1 Yes 2 X No ntry? Han Indian, etc. t e dustry ring MD 20906 er Spring Down, State
Bedford Court Assisted Living Silver Spring Montgom Funcral Director 5. Social Security Number 0.60 14 - 9 6 4 4	olace (State or Foreign try) NY Od. Inside City Limits 1 Yes 2 XNo otry? ran Indian, etc. t e dustry ring MD 20906 er Spring own, State
Director Direct	ny NY Od. Inside City Limits 1 Yes 2 XNo ntry? Interpretation of the distribution
10a. State 10b. County 10c. City, Town or Location 10c. City Town or Location 10c. City, Town or Location 10c. Cit	1 Yes 2 XNo ntry? an Indian, etc. t e dustry ing MD 20906 or Spring own, State
17. Father's Name (First, Middle, Last) Arthur Seebach 19a. Informant's Name/Relationship (Type, Print) Rose Anne Seebach/wife 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, middle, Maiden Surmame) 18. Mother's Name (First, Middle, Maiden Surmame) Matilda Kradick 19a. Informant's Name/Relationship (Type, Print) Rose Anne Seebach/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Saddress of Feeliby I lins Funeral Home 5 CO University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 15b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 25c. Location - City or Town 25c. Marne and Saddress of Feeliby I lins Funeral Home 5 CO University Blvd. W., Silver 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 15c. Marne and Saddress of Feeliby I lins Funeral Home 15c. Name and Saddress of Feeliby I lins Funeral Home 15c. Name (First, Middle, Maiden Surmame) 15c. Matter Saddress (Street and Number or Rural Route Number, City or Town, State, Zip Co. 25c. Location - City or Town 25c. Place of Disposition (Name of cemetery, crematory or other place) 15c. Place of Disposition (Name of cemetery, crematory or other place) 15c. Place of Disposition (Name of cemetery, crematory or other place) 15c. Place of Disposition (Name of cemetery, crematory or other place) 15c. Place of Disposition (Name of cemetery, crematory or other pl	an Indian, etc. t e dustry ing MD 20906 er Spring own, State
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23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease a. Due to (or as a consequence of):	Inc. Spring, MD
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Examiner Sequentially list conditions, b. Essential Hypertension	
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X C T S C C C C C C C C C C C C C C C C C	ery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	an equal of death?
The set of the significant conditions continuous to dearn but not resulting in the dividentlying cause given in Part in Super Significant conditions continuous to the significant conditions continuous	
Normal Pressure Hydrocephalus 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSIST 27. Manner of Death 28a. Date of injury 28b. Time of injury at 1 28d. Describe how injury occurred	psy findings available mpletion of cause of
performed? death? 1 Yes 2 \overline{\text{Ves case referred to medical}} 25. Was case referred to medical 26. Place of Death (Chark only one)	2 🗍 No
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Noursing Home 5 Residence 6 Other (Specify)	ea Living
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29a. Certifier (Check only one) 29a. Certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, 20d.) 24d. 24d. 24d. 24d. 24d. 24d. 24d. 24d.	use(s) and manner stated.
29b. Signature and title of certifier 29c. License number D 2 3 9 5 8 D 2 3 9 5 8 D 2 3 9 5 8	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burt I. Feldman, MD 3305 N. Leisure World Blvd. Silver Spri	
State Registrar 1. Date filed (Month, Day, Year) 32. Registrar's Signature	ng. MI

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Joseph Stotsky January 25, 2014 3:20 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) ep 5, 1944 219-42-9444 1 🔀 M 2 🗆 F Months Days Hours Min Maryland 66 **Director** Sep Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Maryland Carroll Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21787 USA 4324 Harney Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give white Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) School Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Adam Stotsky Anna Casson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4324 Harney Road, Taneytown, MD 21787 Page 1 and 2 Dixie Lee Stotsky, wife Baltimore, 20b. Place of Disposition (Name of Schretchy, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State 1/26/2011 Winfield, MD Carroll Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Wu 4/2006-1123/11 Medical Examiner Due to (or as a conseque it e of): Sequentially list conditions, if any leading limit cause. Enter Underlying Cause (Disease or linjury Examine Due to jor as a conse vience of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 ☐ No 9 Unknown q Unknown signed by till ld be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Donknown Completed **Director:** After this certificate has been siden by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 140 Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours aff
To the Funeral Di
completed filled in Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WIL death (Item 23a) (Type, Print)

|0 |State

DHMH 17 Rev 7/2009

Registrar

32. Registrar

JAN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Shrader Patricia Diana 2011 2.45 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie 8309 Cowan Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr. 20 g. Birthplace (State or Foreign Social Security Number 7, Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 🗆 M 2 🗶 F Months New Jersev 158-48-0823 56 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Prince George's Bowie 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U. S. A. 8309 Cowan Avenue 20720 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", 3 Divorced 4 Divorced Completed Medical 16b. Kind of Business Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City of Bowie permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maryland 4 Social Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ McHale Charles С. Coscia Theresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Shrader / Husband 8309 Cowan Avenue, Bowie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bartimore Washington 1/19/2011 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematoriam 11/15/2011 | 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee any .6000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final М٥ Physician/ Myeloma YYS. disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the attending p IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practice or. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) e and title of certifier D0058213 1/18/11

(PP, Print)
12150 Annapolis Rd Gleun Dali
2076

State

Registrar

30. Name and address of person who

JAN20

31. Date filed (Month, Day, Year)

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

JAMALI

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#10e, 18, 23A State of Maryland / Department of Health and Mental Hygiene? 1 - State per FH, PHY, 2/8/2011 AACO HEALIH OMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IRIE 952 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) 76 Courte A. Director 551-46**-**2804 0/16/1934 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Stevensville 1 🗌 Yes 2 🔀 No Queen Anne 10e. Street and Number 200 Terrapin Grove #1150f. Zip Code 10g. Citizen of What Country? Funeral 200 Terapin Grove 21666 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Yes 2 No Yes, Give X Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 X Widowed 4 Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ျ Hollie Stone Rosella Welsh Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jahan Sampson Grand Son 500 Lighthouse Drive Perryville, MD 21903 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 01/16/2011 Glen Burnie,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Tali Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death KENA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of) the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Pregnant at time of death 2 100 Day Yes Month Year 9 | Unknown 9 Unknown been signed by should be detact Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of this certificate has 24a Was an autopsy performed death? 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 40 Hospita ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury After 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Accident after death Director; / Investigation 1 ☐ Yes 2 ☐ No filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 118703 0 10 who completed cause of death (Item 23a) (Type, Print) GENEVIEVE DEFENSE HWY ANDAPOL FG HT -1A4 1001 State Registrar's Sign Registrar

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			For State Registrar			Marylar		artmer <i>rtificat</i>		Health and Death		Reg.	201	description of	04032	
	Physici Medi		1. Decedent's Name Basil D.	Stanle	y						2. Date of Month		Bay 2	2877	3. Time of Death	
	Exami	ner	Harford 1	Memorial	ive street and numbe L Hospital					r Location of Dea Le de Gr	ace	4c. County of Death Harford				
	Funeral Director		5. Social Security Nu 214-30-4	563	. Sex 1 🔀 M 2 ☐ F		last birthday) 77 Yrs.	If Under Months	r 1 Year Days	If Under 24 Hr Hours Mir		of Birth 5 Day Yea 5 7 7 93	3	g. Birthi North	place (State or Foreign K) Carolina	
	Maryland 28a-f show otified at	ctor	Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo							1	Od. Inside City Limits	
	the Ma a or 28a be notifi	al Dire	MD 10e. Street and Num				Havre	de G	Code			10g.	Citizen of \		1 Yes 2 XNo	
M	ath with	uner	825 Earl	ton Road	12. Was Decede	nt Ever in II	S 112	Was Doors	210) 7 8 Iispanic Origin? (Specify Vos or	· No-		S.A.	an Indian	
000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Department of Health and Mentai Hygiene. Department of Health and Mentai Hygiene. The mortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Marri	-	Armed Force	s? No		If Yes, spec	cify Cuba	an, Mexican, Pue	rto Rican, etc.)		ce - Americ ck, White,		
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	should and Me is marl		19a. Informant's Na				19b. Maili	ng Address	s (Street	and Number or F	•			State, Zip (Code)	
9	and 2 sem 27 sem 27 ther tr		Steven :	Stanley Position	(Son)	20h I	823 Place of Dispo			Road, H	avre d	e Gra	ce, A	<u>laryl</u>	and 21078	
Baltimore	Page 1 nent of ant: If ii		1 Durial 2		Removal from Sta	ate (cemetery, cre ford M	matory or o	ther plac	ce) 2ns 01/	22/201	- 1				
Balt	permit. Departi Import any inji	١,	Sign ture of Fun	neral Service Lice	ensee 7 10	ma	11 2			ss of Facility Z	ellman	Fune	ral t	lome,	P.A.	
2		+	23a. Part 1. Enter the shock, or heart	he disease, or co	emplications that cau	sed the deat	th. Do not ent	er the mod	le of dyin	hungton ng, such as cardia	ac or respirato	Havhe ry arrest,	de (irace	MD 21078 Approximate Interval Between	
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W _	oe executer iclan and burial-trans	ल	that initiated events resulting in death) L	ast	Due to (or	as a conseq	uence of):									
J. 2	ificate bing phys	Medic	IF FEMALE:		d								1			
STAVIL Box 68760	9 # K	Completed by Physician/Medic	23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcor 1 ☐ Live Bin 4 ☐ Pregnar 9 ☐ Unknow	th 2 ☐ Feta nt at time of	aldeath 3 [Ectopic p		cy		_	1	ate of deliventh	ery Day Year	
0.9	ires that the dea n signed by the a Id be detached fi	d by P	Part II. Other signifi	cant conditions	contributing to deat	1	01	underlying o	cause giv	ven in Part I.					ne cause of death?	
ord	ysician: The law requires s certificate has been sig director, page 2 should b	plete			7	<i>377</i> (3					24a.	Was an	24b.	Were auto	psy findings available mpletion of cause of	
Rec	r: The la icate ha r, page	Com									1 🗆	autopsy performed Yes 2 🖺	?	death?	2 No	
Vita	ysiciar is certif directo	To Be	25. Was case referre examiner? 1 Yes 2 1	_	Hospital:	atient 2 🖪	E R√Outpatie	nt 3 🗆 D0	Oth	er: 4 Nursing	Home 5	Residence	6 ☐ Oth	er (Specify	•)	
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigat 6 Could not determine	t be 28e. Place of	Injury - At ho	ome, farm, str	M eet, factory		Yes 2 L No		ion (Street r Town, Sta		er or Rura	Route Number,	
	e Hospita 124 hours e Funeral leted filled	Medical	(Check 2	Medical Exa	hysician: To the best miner: On the basis ourse Practioner: To t	of examinatio	n and/or inves	tigation, in r	my opinio	on, death occurred	d at the time, o	date and pla	ace, and du	e to the ca	use(s) and manner stated.	
	To the within To the comp	2	29b. Signature and t			ne best of m	y knowledge,	29c	. License	e number		29d.	Date signe	d (Month,	Day, Year)	
)		30. Name and addre	ess of person who	o completed cause o	f death (Iten	1 23a) (Ivne 1	Print1	L	1606(5		l	118	2/2011 and sint	
			C . 1	VAR.	MO	<i>s</i> *	66	1 - 5	> - (1	michai	unno,	, DE	ir w d	spec	end sing	
	Sta Registr		31. Date filed (Month	, LIVES	32. Regi	strar's Signa	ture	for constitution	The state of the s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n 4 n 3 3 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 26 Day 20 T Jan 3:59p M Oliver Franklin Schuler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil E1kton 1736 Appleton Rd. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □**X**M 2 □ F Months Days Hours May 6, Yar 37 Country) DE **Director** 221-22-5873 73 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō with 1 23a Funeral IISA 21921 1736 Appleton Rd. items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction 10 Heavy Equipment Operator and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Oliver Schuler Bessie Wyatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 1736 Appleton Rd. Elkton, MD 21921 Emilie Schuler/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State injury or 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) White Clay Creek Cem. 2/1/2011 Newark, DE Name and Address of Facility
T. Foard and Jones, Inc. uneral Service Licensee any Tall a West Main St. Newark, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cause on ach line Mastar Immediate Cause (Final Holeman airoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of r. Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 9 Unknown 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 234) (Type, Print) Ditemmens Run Road Ballo, MD 21221

State Registrar filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06034 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 10:39 AM 01 2011 Charlie Stewart Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, 1 🔯 M 2 🗆 F Days Hours Min. 60 231-68-4076 VA Director Mar Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2X No Forestville Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 20747 USA 6703 Anton Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 1969 Maryland 21215-0036 1 ☐ Yes 2X No Specify. Black. 3 Widowed 4 Divorced Ĭ 973 Completed Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Metro 12th Station Manager other 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked o မှ Marion W. Stewart Maynard Stewart and 2 should b Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6703 Anton Dr. Forestville, MD. 20747 Diann L. Stewart-Wife permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other to Baltimore, 20b. Flace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State MD Veterans Cemetery 2-3-2011 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland Suitland, MD. 20747 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 10 years Diabetes Mellitus Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exam law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician ator use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 🗆 No the hed 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed b should be deta Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown End Stage Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performed? Hospital or Attending Physician: The 1 ☐ Yes 2xxx No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA this (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No death. vithin 24 hours after death.

• the Funeral Director: All ompleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Aurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 □ within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 1(VA) D18089 Jan. 21, 2011

State Registrar Steven M.

31. Date filed (Month, Day, Year)

2011

Pollak 7500 Greenway Center Drive Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $01/25^{\circ}/2011^{\circ}$ 3:45 pm Ear1 Thompson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Calvert Calvert County Nursing Center Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**▼** M 2 □ F Days Hours Country) 218-07-5611 0471871918 MD Director Usual Residence of Decedent 28a-f show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince Frederick MD Calvert 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20678 2510 Fawn Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. <u></u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 x Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file r and Mental H ris marked of Robert Thompson Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 39159 Rodeffer Road, Lovettsville, VA 20180 Robert Thompson/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John Vianney Cem 01/29/2011 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Prince Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ LUNG CANCER disease or condition resulting in death) 6 MUNTHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury that initiated events Due to (or as a consequence of) g physician and sthe burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE /es, outcome of pregnancy

Live Birth 2 | Fetal death 3 | Ectopic pregnancy

The string of death 5 | Other (specify) | ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILVRE Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 1 🗌 Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical of Vital B B 26. Place of Death (Check only one) 2 No 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D2 6358 KW TAN. 26.2010 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) John M. Weigel, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Darke enus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 26 Month Physician/ Patricia Travers 0026 2011 Januar Medical 4c. County of Death 4a. Facility Name (if got institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SAlisbury Wicomico Kegional Medic enter If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 11/20/1953 Country)
New York Days Hours Min 1 □ M 2 🏿 F 079-46-1140 57 Director Usual Residence of Decedent 10d Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🖁 Yes 2 🗆 No Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21804 USA 314 Mill Pond Lane, Apt. 423 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) event, the Practical Nurse Health Care Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Dorothy Mae Rollins Eldon Grand Eldred traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brian M. Travers/spouse 314 Mill Pond Lane, Apt. 423, Salisbury, MD 21804 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Palmyra Village Cemetery Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 1/31/2011 Palmyra, NY Donation 5 Other (Specify) of Funeral Service Licensee natur Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examinet Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown as been signed by a 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed After this certificate has page Yes 2 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Tes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work?
1 Yes 2 No s after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29a. Certifier (Check

29b. Signature and title

loughas 31. Date filed (Month, Day, Year)

JAN 27 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E.

32. Registrar's Signatu

within 2 To the F

Carroll

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

51.

SALISburc

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 1135 HOLLAND VINYARD JANUARY 2011 HELEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year I If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Social Security Number Days Hours Min. 1 □ M 2 🗓 F Months JUNE 22, Year) 921 418-22-5469 AT ABAMA Director 89 Usual Residence of Decedent shov 10b. County 10a State 10c. City. Town or Location event, the Merical Examiner must be notified at 10d. Inside City Limits Director 28a-f MILLSBORO 1 Tes 2 X No DELAWARE SUSSEX 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2011 Funeral USA items 23a 19966 3 HUNTERS POINTE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 21215-0036 ō 1 Never Married 2 Mamied ģ WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: and Mental Hygiene.
is marked other than "natural", Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ex IRENE SOLOMON HOLLAND LESLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 ABBOTT PLACE, OCEAN PINES, MD 21811 GEORGE P. VINYARD JR./SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State CREMATORY OF DELMARVA 1/26/11 DELMAR, DELAWARE 4 Domation 5 Other (Specify) 21. Sign vure 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Citysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 Yes 2 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should 24a. Was an 24b. Were autopsy findings available SBC prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a, Certifier Certifying Physician: 16 the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres Aleh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>2</u>01°1 9:25 A M Dorothy Elizabeth Walker January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min North Carolina **Director** 220-22-3684 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No MD Calvert Owings 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 330 Mt. Harmony Road East 20736 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 **X** No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Naval Academy Contract Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Spann Pauline Ryznar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 Mt. <u>Kevin Walker, son</u> Harmony Road East, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01-27-11 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final √ nysician/ disease or condition resulting in death) Mume Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical ANASARO Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Completed 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' death? this certificate 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 []Kin ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mannet of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funera Natural work? 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 70855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sidhi Prince Frederick, mp zours 100 Huspita 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

AN 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month ver 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Med CA mor TIMOR 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday, If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Dec. 30, 1937 **Funeral** Hours Maryland 1 X M 2 - F Director 218-34-1312 73 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count the Medical Examiner must be notified at Director MD Anne Arundel 1 ☐ Yes 2 🛛 No Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 16 Chesapeake Mobile Court 21076 USA or items death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 1961 1962 Black, White, etc. 1 Never Married 2 XMarried þ Maryland 21215-0036 White 1 ☐ Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan 3 Ulidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Mechanic Trucking Companies 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton Watts Marie Shenton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Royal Beach Road Pasadena, MD 21122 Darla Kaye Watts / Wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) January 22 Metro Crematory, INC. Baltimore, MD 2011 Signature of 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral H
495 Ritchie Hwy, Severna Park, MD 21146 Emperal Service Licenses Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami and that initiated events resulting in death) Last burials been signed by the attending physician should be detached for use as the burial Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 No g Unknown g | Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 ☐ Yes 2 ☑ 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 🗆 only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

State Registrar a

2011

31. Date filed (Month

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17,2011 Physician/ 8:05A M January Richard Lee Whitaker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arunde1 <u>Annapolis</u> 1603 Meeting House Lane If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Funeral Days Hours 1 X M 2 - F Months 3/18/1937 216-34-1678 73 KY Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1 Yes X No Annapolis Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21403 64 Silopanna Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Grocery Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Whitaker Elsie Dowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 270 Maple Wreath Ct. Abingdon, MD 21009 Jacqueline Whitaker daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/21/2011 Annapolis, MD Hillcrest Cemetry 22. Name and Address of Facility 21. Signature of Fund I Service Licens 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. Tar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians disease or condition resulting in death) vocard Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi obacco that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) ☐ Yes ☐ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar 3

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 20

Medical

ss of person who completed cause of death (Item 23a) (Type, Print)

2002

32. Fegistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Suit SUC Annapolis MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrar	of Maryland / Depa Cen	irtment of H <i>tificate of D</i>		Mental Hygie Reg.	$=2.01 \pm 1$	04041
Physicia	n/	1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·			2. Date of Death		3. Time of Death
Medic Examin	al	JULIANN M. WALTE		4b. City, Town, or I	Location of Death		4c. County of Death	
		HOMESTEAD MANOR ASSIS		DENTON,	MARYLAN	ID	CAROLINE	COUNTY
Funeral Director		5. Social Security Number 219-38-5429 6. Sex 1 ☐ M 2 🗶	F 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birth BALT	nplace (State or Foreign ntry) • CO • , MD
yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County DELAWARE SUSSEX COUNT	10c. City, Town or Loc TY DAGSBORO	ation				10d. Inside City Limits
the Mar or 28a oe notifi	Funeral Director	10e. Street and Number	DAGSBORO	10f. Zip Code		1 0	. Citízen of What Cou	,
ath with rms 23a must b	unera	132 RIVER BEND DRIVE	ecedent Ever in U.S. 13. W	19939			UNITED STA	
ours after des tural", or ite	by	1 Never Married 2 Married 1 Yes,	Forces? If	/as Decedent of His Yes, specify Cuban ☐ Yes 2 X No	, Mexican, Puerto		14. Race - Ameri Black, White, Specify: WHI	etc.
If yield I Z I Z I D-UUJO ould be filed within 72 hours after death with the Maryland old Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed properties) Elementary/Seconday (0-12) College 2	ted) (Give k life, DC	ent's Usual Occupa ind of work done du NOT use retired) FER SYSTE	iring most of work	king D1	o. Kind of Business tr EPT. OF DI S GOV'T. (
be filed vental Hygrked other	To Be	17. Father's Name (First, Middle, Last) UNKNOWN				ne (First, Middle, Maid	len Surname)	
2 shull the and the an		19a. Informant's Name/Relationship (Type, Print) WILLIAM M. WALTERHOEFE				ral Route Number, City		Code)
of Her		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)		sition (Name of atory or other place	M. JAN		c. Location - City or T	
Deficiency permit. Page Department of Important: If any injury or once.		21. Signature on Funeral Service Dicessee	22.	Name and Address	of Facility	E PO BOX		
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rate be executed physician and the burial-transit	dical Examiner	Cause (Disease or linjury that initiated events c	to (or as a consequence of):		_			
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the Hospital or Attending Physician: The law requires that the death certific hin 24 burus after death. The House after death the sertificate has been signed by the attending the Funeral Director. After this certificate has been signed by the attending propered filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 mooths? 1	outcome of pregnancy ive Birth 2 Fetal death 3 regnant at time of death 5 nknown	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
uires that the des	þ	Part II. Other significant conditions contributing t	o death but not resulting in the un	nderlying cause give	n in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
The law require sate has been si page 2 should I	Completed					24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of
Physician: The this certificate ral director, pag		25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpatient	Other	ce of Death (Chec			Assisted
nding Phy th. After this funeral of		27. Mann Death 28a. Da	ate of injury 28b. Time of injury injury	28c. Injury a work?	at	ome 5 Residence 28d. Describe how in		First
To the Hospital or Attending In within 24 hours after death. To the Funeral Director: After completed filled in by the funeral	Certificate:	3 Suicide 6 Could not be	ace of Injury - At home, farm, stree ilding, etc. (Specify)			28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
e Hospita n 24 hours e Funera	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	e best of my knowledge, death or basis of examination and/or investi er: To the best of my knowledge, de	gation, in my opinion	, death occurred a	it the time, date and pla	ace, and due to the ca	ause(s) and manner stated.
To th withir To th comp		29b. Signature and title of certifier	MIS	29c. License		29d.	Date signed (Month,	
		30. Name and address of person who completed c	ause of death (Item 23a) (Type, Pr	int)	· 750	ston 1	G CN	1455
Stat Registra	•	31. Date filed (Month) Phy. 3a1 2011	Registrar's Signature	Sh	•			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24^{Day} January Physician/ 2011^{ear} 8:10 Αм Margaret Priscilla Wooters Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton Caroline Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** October 2, 1912 1 □ M 2 X F Months Hours CouMaryland Director 217-36-1183 98 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Denton Caroline Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. 21629 25530 Hignutt Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Family Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Susan Marie Hunter Edgar Sothern Willis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 701 Camp Road, Denton, Maryland Dorsey Wooters/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Denton, Maryland Jan. 27, 2011 4 Donation 5 Other (Specify) Denton Cemetery 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service License 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) 16345 Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to lor as a consuluence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 4 Pregnant a 9 Unknown Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNC Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

State Registrar

DHMH 17 Rev 7/2009

JAN 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Dat, Year)

Certifying Nurse PractioneryTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 2:45 P. Lillie Louise Wheeler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince George's HCR Hvattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday Funeral Months Days Hours Min. (Month, Day, Year) 08/10/1942 Country) 1 M 2 K 68 Director McBee.S.C 248-68-0008 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 335 Division Ave., N.E. 20019 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: "natural". 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Fant: If item 27 is marked other than jury or other traumatic event, the N Mentally Challenged 11th Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Robinson Alberta English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 Division Ave., N.E., Washington, D.C. Richard E. Wheeler/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington Nat'l. Cem. 02/05/11 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. aur 20019 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Buccal Squamous Cell Cancer with Metastasis disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events Hypernatremia and -tran Due to (or as a consequence of) resulting in death) Last the burial attending physician Physician/Medical Hypoglycemia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed?

1 Yes 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔼 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Investigation Accident after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) 24 hours Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c, License number 29d. Date signed (Month, Day, Year) D0070459 January 29,2011

State Registrar 7245 Hanover Pkwy, # B, Greenbelt, Maryland

erson who completed cause of death (Item 23a) (Type, Print)

Oludara, M.D.

1. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:40 A^M 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton 29537 Golton Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number Year) **Funeral** Days Hours Min Months 1 ★M 2 ☐ F May 9, Maryland 64 Director 212-44-003<u>4</u> Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is "redical Externisation to the traumatic event, It is "redical Externisation to any injury or other traumatic event, It is "redical Externisation to any injury or other traumatic event, It is "redical Externisation to a second to the page 2. 28a-f show 1 XYes 2 ☐ No Directo Easton Maryland <u>Talbot</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 U.S.A. 29537 Golton Drive Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: þ White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 12 H.S. Grad. Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Anna Kahl Walter Henry Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21601 29537 Golton Drive, Easton, Maryland Darlene Young 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 1, 2011 Dover, Delaware Capitol Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 OUVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a c quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the a d be detached for P.0. I ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No ficate has been sli r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, page 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. 2 (Vo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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2. Registrar's Signature

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2301 201 Physician/ Charles Zimmer Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Wicomico Salisbury Peninsula Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 (Month, Day, Year) 1 0 - 6 - 1 9 3 5 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex 1 ★M 2 ☐ F **Funeral** Hours 75 Pennsylvania Director 167-26-4912 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2X No Harrington Kent DE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 19952 USA 1200 Hogtown Road 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) of and 2 should be filed within 72 to Health and Mental Hygiene. If item 27 is marked other than "n rother traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Military USAF Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angeline Neminski Robert Charles Zimmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26813 Walker Rd.Lot 5 Seaford, DE 19973 Rhonda Paulson/daughter 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Summit Cremation
Services. LLC permit. Page 1 a
Department of H
Important: If ite
any Injury or ot Wyoming, DE 1-30-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pippin Funeral Home, Inc. 21. Signature of Funeral Service Licensee 119 W. Camden-Wyoming Ave.Wyoming,DE19934 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . h_y sician/ Pneumonia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cares. From Uncertaing Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Day in the past 12 months? Month Pregnant at time of death cate has been signed by the page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Protein calorie malnutrition, presumed cirrhosis 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? pneumothorax 24a. Was an To the Hospital or Attending Physician: The law I within 24 hours after death.
To the Funeral Director. After this certificate has E completed filled in by the funeral director, page 2 s autopsy performed? 2 🗌 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 III Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work? 1 🗌 Yes 2 🗀 No (Month, Day, Year) injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

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and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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William DeLong Anderson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland /	Department of I	Health and Me	ntal Hygiene

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### February 5, 201 Z253 mm Anne Arundel Medical Center ### Ann	Physici			lle,Last)							
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385-40-0594 Month	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of Bir	th (MM/DD/YYYY	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 11:30 PM 2011 February Albaugh Doris June Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Center Towson 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** (Month, Day, Y Year) Days Hours Min. 1 □ M 2**X** F Maryland Director 81 179-20-9252 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10c. City, Town or Location 10a. State Director 1 🛛 Yes 2 🗌 No Emmitsburg Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21727 331 S. Seton Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married ş 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) clothing factory seamstress 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Blanche Feeser Norman Harrison Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emmitsburg, MD 21727 P.O. Box 601 George W. Albaugh/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State All County Cremation 2/11/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signary of weral Service Ligansee New Windsor, MD 21776 310 ChurchSt. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death pro unon 6 Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Year Day Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ within 24 hours at er death.

To the Funeral Director: After this funeral . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 🔁 Natural Accident
Control
Contr Investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 only one e and title of certifier 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RON

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death For State Registrar 3. Time of Death 2. Date of Death Yea 1.300 Decedent's Name (First, Middle, Last) Month 701 February Ayzenberg Physician/ Moisey 4c. County of Death 4b. City, Town, or Location of Death Medical 4a. Facility Name (if not institution, give street and number) **BALTIMORE Examiner** RANDALLSTOWN 9. Birthplace (State or Foreign NORTHWEST HOSPITA 8. Date of Birth If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) CountryUKRAINE 0777871927 Social Security Number 1 M 2 D F Funeral 83 212-94-9039 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 1 🗌 Yes 2 🛣 No ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State REISTERSTOWN the Maryland Funeral Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21136 300 SALONY DRIVE, #215 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X X No If Yes, Give Black, White, etc 11. Marital Status WHITE Specify: 1 Yes 2XXNo Specify: 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". MANUFACTURING College (1-4 or 5+) Elementary/Seconday (0-12) **ENGINEER** 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) SOYFER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မ **AY ZENBERG** REISTERSTOWN, MD 21136 19a. Informant's Name/Relationship (Type, Print) #215 300 SALONY DRIVE, 20c. Location - City or Town, State LIA AYZENBERG/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition OWINGS MILLS, MD 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 02/11/2011 SINAI CEMETERY 22. Name and Address of Facility SOL LEVINSON & BROS., 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee PIKESVILLE. 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death COPD Immediate Cause (Final disease or condition End-Stage Physician/ Due to (or as a consequence of) resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limitury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE: Year 3 Ectopic pregnancy
5 Other (specify) Month Day 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown sate has been signed by the atterpage 2 should be detached for the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsv performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director, to a completed filled in by the funeral director, to the funeral director, the funeral director is the funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 W No 28d. Describe how injury occurred Certificate: To 28c. Injury at 28b. Time of 28a. Date of injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 27. Manner of Death injury 5 Pending Hospital or Attending 1 Natural 28f. Location (Street and Number or Rural Route Number, City or Town, State) after death. investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide
4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Oertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29c. License number D0057465 29b. Signature and title of certifier no Rajapahre M.D Baltimore, MD. 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N'S Ray as a KSE, M.O. 2835 Smith N. 5-203, State Registrar

DHMH 17 Rev 7/2009

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s been signed by the attending physician and U. 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions conditions.	Due to (or as a concept of the body of the	pregnancy Fetal death 3 ne of death 5	☐ Ectopic pregr ☐ Other (specify	CERTIFICATION AF	23e. Dic 1	d tobacco us Yes 2 s an opsy formed?	3d. Date of d Month se contribute No 3 I 24b. Were a prior t death' 1 Ye	lelivery Day Yea to the cause of deal Probably 4 □ Unk autopsy findings ava o completion of cause es 2 □ No
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4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tentral pirector, page 2 should be detached for use as the burial-transit tensit.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to intrivediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions? 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 27. Manner of Death Natural Significant Significant Natural Significant Natural Significant Natural Significant Natural Significant Sign	Due to (or as a control of the contr	pregnancy Fetal death 3 ne of death 5 not resulting in the 2 ER/Outpatic ear) 28b. Time Injury At home, farm, s Specify) my knowledge, deaxamination and/or	Ectopic pregr Other (specify underlying cause and 3 DOA of 28c. M ath occurred at the	certification of an analysis of the control of the	23e. Did 1 24a. Wa aut per 1 Yes ath Check onl Home 5 Re 28d. Describ 28f. Location City or To	d tobacco us Yes 2 s an opsy formed? No one) sidence 6 e how injury (Street and own, State)	3d. Date of d Month se contribute No 3 24b. Were prior the death 1 Ye Occurred Occurred	Day Year to the cause of deat Probably 4 □ Unkr autopsy findings ava o completion of caus? es 2 □ No pecify) Rural Route Number as stated.
4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tentral pirector, page 2 should be detached for use as the burial-transit tensit.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions? 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions conditions conditions? 27. Manner of Death	Due to (or as a control of the second of the	pregnancy Fetal death 3 ne of death 5 not resulting in the 2 ER/Outpatic ear) 28b. Time Injury At home, farm, s Specify) my knowledge, deaxamination and/or	Ectopic pregr Other (specify underlying cause ant 3 DOA of 28c. M Attreet, factory, off atth occurred at til investigation, in	certification of an analysis of the control of the	23e. Did 1 24a. Wa aut per 1 Yes ath Check onl Home 5 Re 28d. Describ 28f. Location City or To	d tobacco us Yes 2 s an opsy formed? No one) sidence 6 e how injury (Street and own, State) the cause(s) ne, date and	3d. Date of d Month se contribute Alo 3 24b. Were a prior to death 1 Ye S Other (Sp y occurred d Number or and manner a place, and o	lelivery Day Year to the cause of deat Probably 4 Unkr autopsy findings ava o completion of caus es 2 No necify) Rural Route Number as stated.
after death. Director: After this certificate has been signed by the attending physician and July the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to intrivediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	Due to (or as a control of the second of the	pregnancy Fetal death 3 ne of death 5 not resulting in the 2 ER/Outpatic ear) 28b. Time Injury At home, farm, s Specify) my knowledge, deaxamination and/or	ent 3 DOA of 28c. Math occurred at thinvestigation, in 29c. Lice	certification of the company opinion, death occase number	23e. Did 1 24a. Wa aut per 1 Yes ath Check onl Home 5 Re 28d. Describ 28f. Location City or To	d tobacco us Yes 2 s an opsy formed? No one) sidence 6 e how injury (Street and own, State) he cause(s) he, date and 29d. Date	3d. Date of d Month se contribute 24b. Were a prior to death 1 Ye 3 Other (Sp y occurred d Number or and manner d place, and designed (Month)	lelivery Day Year to the cause of deat Probably 4 \(\subseteq \text{Unkr} autopsy findings ava o completion of caus? es 2 \(\subseteq \text{No} \) Rural Route Number as stated, due to the cause(s) inth, Day, Year)
4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tentral pirector, page 2 should be detached for use as the burial-transit tensit.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to intrivediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	Due to (r as a c Compared to for as a c Compared to	pregnancy Fetal death on resulting in the 2 ER/Outpatie ear) At home, farm, s Specify) my knowledge, deaxamination and/or	Ectopic pregr Other (specify e underlying cause ent 3 DOA of 28c. / M ath occurred at the investigation, in	certification of the control of the	23e. Did 1 24a. Wa aut per 1 Yes ath Check onl Home 5 Re 28d. Describ 28f. Location City or To	d tobacco us Yes 2 s an opsy formed? No one) sidence 6 e how injury (Street and own, State) he cause(s) he, date and 29d. Date	3d. Date of d Month se contribute Alo 3 24b. Were a prior to death 1 Ye S Other (Sp y occurred d Number or and manner a place, and o	lelivery Day Year to the cause of deat Probably 4 \(\subseteq \text{Unkr} autopsy findings ava o completion of caus? es 2 \(\subseteq \text{No} \) Rural Route Number as stated, due to the cause(s) inth, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 09 Physician/ **FEBRUARY** 2011 12:00 ROME Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALT IMORE 3440 ASSOCIATED WAY, #104 OWINGS MILLS Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**XX**M 2 □ F Months Hours 0372871925 85 **Director** 219-18-6650 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **BALT IMORE** OWINGS MILLS 1 ☐ Yes 2 🜠 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3440 ASSOCIATED WAY. 21117 USA #104 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: WHITE 3 W Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) **PHARMACIST** PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **GERTRUDE** MILLSTONE BERLIN ABRAHAM 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL BERLIN/SON GEORGES STATION ROAD. REISTERSTOWN, MD 21136 686 20a. Method of Disposition
1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) OHEB SHALOM MEM.PARK 02/11/2011 REISTERSTOWN, MD 22. Name and Address of FacilitSOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Man Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final the Physician/ 105 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cetopic pregn. 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death 9 Unknown 9 Unknown us certificate has been signed by ti director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 24 hours after death.
Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🔀 Natural injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bitman Physician/ Month Year 6' 4UP M Samuel February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **BALT IMORE** RANDALLSTOWN SEASONS HOSPICE **ONORTHWEST HOSPITA** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Months Hours 08/07/1912 98 **Director** 212-18-0074 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗆 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i Funeral USA 6210 PARK HEIGHTS AVENUE, #403 21215 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2XXNo
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/1 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER LIOUOR RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MEYER BITTMAN MINNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau BETTYE ROSE KERSHNER/DAUGHTER 412 DEER HOLLOW DRIVE, MT. AIRY, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemeter, CRISTON of other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) AMUNO 02/11/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Fungral Service Lig 21. Siar 5900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Atheroscherotic Cardiovascular Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Examin or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The definition of the desist of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns Rajapahrem.D D0057465 2/10/11

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. S. RAMPAKH, M.D. 2835 S.M.M. Av. S. - 203, Baltimore, MD. 21109

32. Registrar's Signature

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per Phy G912 2/14/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris Cottingham Doors 2011 February 9:18A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kline Hospice House Mt Airv Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 X F Country) Maryland Director 219-20-4975 82 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Frederick Walkersville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Sandstone Drive, Apt. 106 21793 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. à 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Telephone Operator Aluminum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Theodore Gossard Katherine Turner Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice L. Murray / Daughter 8420 Crum Road, Walkersville, MD 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 02/07/2011 | Hanover, Maryland 21. Signature of F reral Survio 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, ocomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final Physician/ Pulmonizy To brosses disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last physician and the burial-trans Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Por Month Pregnant at time of death 5 Other (specify) the detached g Unknown P.O. | ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? by Hypertension Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? death? certificate 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospice 1 Tyes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify, After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural within 24 hours after death.

To the Funeral Director; A completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b, Signature and title of certifier 29c. License number 06 Feb 7 of death (Item 23a) (Type, Print)
APP+ # 104 Walkersville, MD 21793

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:00 PM **Physician** S Te /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Point TUTURR DUNDAL ARE If Under 1 Year 8. Date of Birth Month, Day MAY 2.5 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 ☐ M 2 🕮 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Mostical Examination rust be notified at 1 ☐ Yes 2 No Director LARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." any injury or other traumatic events. 10 21220 Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 MaNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) HOME 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) CUAUGH (R) 19b. Mailing Address (Street and Num er or Rural Route Number, City or Town, State, Zip Code) Hocken brock KAVANAU9h Nathleen 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BAltiMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) Facility ChejNACK: FUNERAL HUMES P.A. 1005 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 125050 ard ova scu **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or saila nonsequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐ No this certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar

DHMH 17 Rev 1/2001

mers Run Ris

Name and address of people who completed cause of death (Item 23a) (Type, Print)

/Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physician

"/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show diral Examiner must be notified at

artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natu Injury or other traumatic event, the Medical

Department of Important: If any Injury or

Physician

th and Mental h

Director

Funeral

Be Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	21. Signature of Bineral Service Light		ne and Address of Facility $f M$ $f O$ $f D$ $f E$. North $f A$			MD 21202
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	mode of dying, such as cardiac	or respiratory arrest,	nT	Approximate Interval Between Onset and Death
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a consequence of):				
Completed by Physician/Medical Examiner	resulting in death) Last	Due to (or as a consequence of):	Jan 1991		1	
hysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		pic pregnancy or (specify)		23d. Date of de Month	livery Day Year
ted by P	Part II. Other significant conditions of	notributing to death but not resulting in the underlying to the model of the model	ing cause given in Part I.			o the cause of death? robably 4 □Unknown
Complet	1ty pert	ension		24a. Was an autopsy performed 1☐ Yes 2 ☑	I? / death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		
은	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing H	ome 5 Residence	e 6 □Other (Spe	ecify)
ation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Sertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street City or Town, St	t and Number or R tate)	ural Route Number,
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	/sician: To the best of my knowledge, death occurrence: On the basis of examination and/or investig and manner stated.	irred at the time, date and place ation, in my opinion, death occu	, and due to the caus irred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
M	29b. Signature and title of certifier	DN MI)	29c. License number 3500	~	Date signed (Mon. 2 - 1/1 - 2	,

State Registrar 5901 north

32. Registrar's Signature

CHAYUS STYLL BAILMOR MAYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month () 03 Cinci bus 40 PM **Physician** 2011 erome /Medical 4c. County of Death

Buttmore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Middle River Y If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 29, 1935 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1X M 2□ F Maryland 75 216-32-9276 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 6731 5th Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) architectural draftsman 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ada Virginia Anton Frank Cincibus ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6731 5th Avenue; Baltimore, Maryland 21222 Sherry Lorden - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Fineral S. rvi Licensee Ron S. Wagte Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final e me a Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 27. Manner of Death 1 / Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ompletely (Check only one) 29c. License number 29b. Signature and title of certifier

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State Registrar

who completed cause of death (Item 23a) (Type, Print)

D61907

29d. Date signed (Month, Day, Year)

Muce Avenue, Bultonste

32. Registrar' Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4RTER Physician/ Zo(1 0000 Ó Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death IGRE OSPINAL If Under 1 Year If Under 24 Hrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 🗌 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene.
Important If the 27 is marked other than "natural", or any finury or other traumatic event, the Medical Exami 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) econday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20b. 20c 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Littenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final RDIONY f Bysician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Dure to (or sells consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 1 Division of Vital Be 26. Place of Death (Check only one) Hospital Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide 2 \square No 1 Tes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 21202 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ E. Crook 10:05AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City Good Samaritan Nursing Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 3, 1923 1 M 2 X F Months Days Hours Min. MaryTand 213-20-7678 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore Maryland N/A 1 🔀 Yes 2 🗆 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral USA 21206 6005 Eastern Parkway death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married Yes 2 XXVo 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. "natural", 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Secretary Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Minnie Schmidt Philip Germeten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy C. Muller/ Daughter 3002 Clearview Avenue Baltimore Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson Maryland 2/14/11 Signature of Funeral Service Licer 22. Name and Address of Facility Leonard J. Ruck Funeral Home 5305 Harford Road Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition 'n sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been sinned by the Attending Control of the Funeral Director: After this certificate has been sinned by the Attending Control of the Funeral Director: After this certificate has been sinned by the Attending Control of the Funeral Director of th Cause (Disease or linjury that initiated events resulting in death) Last as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No þ Year Month Day Pregnant at time of death 9 Unknown detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 L completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 3 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Aft Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the P 29b. Signature and title

Registrar
DHMH 17 Rev 7/2009

State

death (Item 23a) (Type, Print)

egistrar's Signatur

30. Name and address of person who completed cause

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Medic Examin		4a. Facility Name (if not institution, gi	ve street and numb	*			, Town, or laurel		of Death			County of D	eath	orges	
Funeral Director		072-16-5584	Sex 1	'. Age (In yrs. I	-	If Unde Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir April	rth 25,	1923 g.		ace (State or Foreigi York	7
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Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es? 19	43-	Yes, spe	dent of His cify Cuban 2፟ █ No	, Mexican	, Puerto	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:		c.	
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iin 24 hu he Fu n ipleted	Medical	(Check 2 Medical Example (Check 2 Medical Example 2 Medical Exampl		of examination	and/or investi	gation, in	my opinion	, death oc	curred at	the time, date a	and place	e, and due to th	e caus	e(s) and manner stat	ed.
with To t		29b. Signature and title of certifier	Umi			29	. License	T 08	set a)	29d. Da	signed (Mo	nth, Da	y, Year)	
		30. Name and address of person who	completed cause	of death (Item	23a) (Type, Pr	rint) -	Reg	ione	il	ER				1	
State Registra	_	31. Date filed (Month, Day, Year)		istrar's Signat	ure la e	Mille	U								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4.	For State	State of M	aryland	/ Depa	rtment of H tificate of D	eaith an Ieath	d Mental Hy	Reg. No.	0011	01050
		1.	Registrar Decedent's Name (First, Middle, L	ast)	^				2. Date of D	eath Day	Year	3. Time of Death
Physici Med		-	JACQUELI.		171	AVI			Month 2	3	2011 County of Death	3:22fm
Exami				DICAL			4b. City, Town, or BACTO		< Mi)		place (State or Foreign
Funera Directo		5.	Social Security Number 6. 219-76-3883	Sex 1 M 2 F	ge (In yrs. last 47	birthday) Yrs.	Months Days		Min. (Month, L	ay, Year) 5 196	Cou	
		-	sual Residence of Decedent		I 100 City 1	Town or Loc	eation					10d. Inside City Limits
yland -f sho	ctor	10	a. State 10b. County	~ ~		imor						1 X Yes 2 □ No
e Mar or 28a notifi	Dire	10	MD e. Street and Number	na	Daic	IMOL	10f. Zip Code			10g. Cit	izen of What Cou	untry?
with the 23a c	Funeral Director		315 Forest	Street			2120				USA	
Naryland 21213-UU30 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	d by Fun	١.	. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces d 1 Yes 2 If Yes, Give Year or Dates.	?		Vas Decedent of H FYes, specify Cuba		i? (Specify Yes or N Puerto Rican, etc.)		14. Race - Amer Black, White Specify: Bla	, etc.
Maryland 21213-0030 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	-	15. Decedent (Specify only highest Elementary/Seconday (0-12)	s Education grade completed) College (1-4 or		16a. Deced (Give I life. De	lent's Usual Occup kind of work done (O NOT use retired)	ation D during most o	isabled	16b. K	ind of Business I	Disabled
d with dygien ther ti	Be		12th grade 7. Father's Name (First, Middle, La.	st)				18. Mother	s Name (First, Midd	le, Maiden	Surname)	
land be file ental H ked o	2		Streta Davis						lie McL			
ary should and M is man		1	9a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number	or Rural Route Num	ber, City or	Town, State, Zip	Code)
P, M and 2 s Health am 27 her tra			Sallie Mae D	avis-Moth	20h Pla	ace of Dispo	sition (Name of		Date Dail	20c. L	ocation - City or	Town, State
nore		12	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from Sta	. ce	meterv, crei	natory or other pla of Fai	ce) .th 2	2-10-201	1	osedal	e, MD
Baltimore, Marylan permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en	ouce.		1. Signature of Funeral Service Lic	censee]]		North	Avenue	Ва	F/H lto, M	D 21202
			23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final	complications that causely one cause on each I	ed the death. ine.	Do not ent	er the mode of dyi	ng, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physicia Medic	al		disease or condition resulting in death)	a. Due to (or a	as a conseque	ence of):	SDS	mA				
Examin		5	Sequentially list conditions, if any, leading to immediate	b. Oue to for s	E a correction	ence of						
ed	Evaminer		Cause. Enter Underlying Cause (Disease or iinjury	Se	051	5						
execut an and rial-tra	Į ž		that initiated events resulting in death) Last	Due to (or a	as a consequ	ence of):						Į.
60 ate be only sicial	100	200		d								
ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Ohn in	SICIALLY INC	F FEMALE: 23b. Was decedent pregnant in the past 12 mounts? 1 Yes 2 No	23c. If yes, outcor 1 Live Birl 4 Pregnar 9 Unknow	th 2 🗌 Feta nt at time of d	I death 3	☐ Ectopic pregna ☐ Other (specify)	ncy			23d. Date of d	elivery Day Year
cords, P.O. E law requires that the d nas been signed by the e 2 should be detache			g Unknown Part II. Other significant condition			ulting in the	underlying cause	given in Part I				o the cause of death? Probably 4 \square Unknown
has has		Completed by							. 1 :	Vas an autopsy performed? Yes 2	prior to	utopsy findings available completion of cause of es 2 \sumbed No
ital Residual The Certificate Prector, page		S P	25. Was case referred to medical examiner?			/			th (Check only one)			
ision of Vital Attending Physician: ar death. ector: After this certific by the funeral director,	١,	ا 2	1 Yes 2 No	Hospital: 1 In		ER/Outpati	ent 3 L DOA	4 ∐ Nt	ursing Home 5 1		6 ☐ Other (Spe ury occurred	ecify)
n of Jing P h. After t		äte	27. Manner Death 1 atural 5 Pendir 2 Accident Investi	ng (Month,	Day, Year)	injury	w	ork? Yes 2	No			
Division of No the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this Completed filled in by the funeral		Certificate:	3 Suicide 6 Could 4 Homicide determ	not be ined 28e. Place of building	, etc. (Specify	/)	street, factory, offic		City o	r Town, Sta	ite)	Rural Route Number,
DIVI Hospital or 24 hours afte Funeral Div		Medical	29a. Certifier 1 Pertifying (Check Medical I	Physician: To the bes xaminer: On the basis Nurse Practioner: To	t of my know of examinatio the best of m	ledge, deat n and/or inv	h occured at the til estigation, in my op e, death occurred at	ne, date and inion, death of the time, date	place, and due to the courred at the time, of and place, and due	to the caus	se(s) and manner	as stated.
To the I within 2 To the I		Σ	only one) 3 L Certifying 29b. Signature and title of certifie		/	4 6		nse number	.7 C	29d.	Date signed (Mo	nth, Day, Year)
			+ fever O	Sol	of do-th "to	230)/5::-	Print	41	1 > 5		2/03	1 2011
,—			30. Name and address of person	who completed cause	death (Iten	n 23a) (Type	MER	CY	MEDIC	AL	CE.43	ER
	Stat		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ature						

DHMH 17 Rev 7/2009

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Mary Levern Dol			ate of Maryla					Mental I	Hygiene		20		0105
		1- For State Registrar	U	Cen	tificate o	of Deat	n		2. Date of D	Reg. No).	3 Tim	e of Death
Physicia Medical Exami	ın/ ner	Decedent's Name (First, Midd	Mary		obbi				Month Februar	Day ry 8, 20		22:	28 hrs
		4a. Facility Name (if not institution 2505 Lakewood Cour	· -	umber)		4b. City, Park		ocation of Dea	ith		lc. County of Baltimore		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la:	st birthday)	If Und	er 1 Year	If Under 24H Hours M	_	Birth (MN	//DD/YYYY) 	9. Birthplace oreign	(State or
Director		218-60-9110	1 M 2 X F	58	Y	rs.	is Days	Hours	8-	9-19		Country)	N.C.
,		Usual Residence of Decedent 10a. State 10b. County		Inc. City 1	Town or Loc	ation						10d. lr	nside City Limits
d Low any			alto		rkvil							1 [Yes 2 No
Maryland 28a-f show d at once.	S	10e. Street and Number	aito	- Fa	LKVII	10f. Zip	Code			10g. Ci	itizen of Wha		Λ
th the Maryland 23a or 28a-f sho notified at once.	Director	2505 Lakewo	od Cour	-			212	234			USA		
with with be no		11. Marital Status	12. Was De	cedent Ever in U.S	S. 13. V	Vas Decede	ent of Hispa	anic Origin? (Specify Yes or to Rican, etc.)	No-		American Ind	ian, Black,
Baltimore, MD 21215-0036 permit. Pand 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 Never Married 2 X M 3 Widowed 4 Div	1 Yes	2 X No	1 [X No		to result, etc.)		Specify:	Blac	ck
ours a	d b	15. Decedent's Education (Spe						n (Give kind o		16b.	Kind of Busi	ness/Industry	
36 In 72 h	Completed	Elementary/Secondary (0-12)	College (1–4 or 5+)	· ·	Super			,		lousel	ceenii	na
-00% I withi grene.	E	17. Father's Name (First, Middle							ne (First, Midd			теерт	19
215 oe filee ntal Hy ked o	Be	Ira K. John						Betty	Glas	s			
21, nould b is mar	힏	19a. Informant's Name/Relations	ship (Type, Print)	Husband					r Rural Route I				
MC 2 sl alth an		Charles E. 20a. Method of Disposition	<u>Dobbins</u>		250 lace of Disp				urt Pa		rille /		
Ore, es la of He If ite		1 Burial 2 Cremation	n 3 Removal f	rom State Cr	rematory or	other place							o lato
timent rtment rtment		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	Gr	eenmo	unt Name and	Address		12-20				
Bal permi Depar injur		21. Senature or uneral service	Clorisee		22.			-	Aven		st F/ Balto		21202
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that	caused the death.	Do not enter	the mode	of dying, s	uch as cardiad	or respiratory	arrest, sl		Appr	roximate Interval
/Medical Examiner		Immediate Cause (Final disease	A46	rotic Cardiova	scular Di	isease							Death
Jan	9	or condition resulting in death)	Due to (or as	a consequence of)	:								
	ē	Sequentially list conditions, if any, leading to immediate		a consequence of)):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C	a consequence of)									
ecuted and - transit		events resulting in death) Last	d.	a consequence on									
e execute sian and sial - trar	ica	UNPENDED	AMENDED										
Box 68760, he death certificate be ex the attending physician hed for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in t	h-	outcome of pregn				7		2	3d. Date of d	-	V
certificant	cian	past 12 months?	LILETON	birth nant at time of dea	- H	Fetal death Other (Spe	3 <u> </u>	_ Ectopic preg	nancy		Month	Day	Year
Box death the atte	nysi	1 Yes 2 No 9 Un	known 9 Unkn	iown		JUNE (-7-							
hat the ed by detache	by P	Part II. Other significant condi	tions contributing t	o death but not re	sulting in the	underlying	g cause giv	ven in Part I.			o use contrib		use of death?
Division of Vital Records, P.O. taal or Attending Physician: The law requires that it as after death. **A Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detact	E E	Chronic Bronchitis							- 24a. W		and the same of		indings available
Ord law red has be	Completed		_						aı	utopsy erformed	pri		ion of cause of
Rec The ficate ; page	5						00 DI	(D - 1) (O)		es 2	No 1	✓ Yes	2 No
lital sician:	a	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatie			of Death (Checother)	sing Home 5	Resid	dence 6	Other: Scene	
of V ig Pby	<u>۽</u>	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time o	f Injury	28c. Injury				njury occurred	1	
ion tendin eath.	ğ		ding estigation	ii, Day, roai)			1 Ye	es 2 No					
or At after d Direct	ţį	3 Suicide 6 Cou	ld not be 28e. Place	ce of Injury - At ho	me, farm, str	eet, factory	, office bu	ilding, etc.		on (Street m, State)		or Rural Rou	ite Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical Certification:	4 Homicide	ermined (Specify						W.			a atatad	
the He nin 24 i	<u>ica</u>	(Check only	hysician: To the be miner:On the basis	of examination an									e(s)
To To Com	Med	29b/ Signature and title of certifi	and manner er	stated		29	c. License	number		290	. Date signed	(Month, Da	y, Year)
		(Cartisles	du				O.C.M	1.E.		Fe	bruary 9,	2011	
_		30. Name and address of person	who completed cau	use of death (Item :	23a)								

State Registrar

31. Date filed (Month, Day, Year) FEB 1 4 2011

Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registrar DHMH 17 Rev 7/2009

State

of Vital

Division

VEERAPPAN N.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SUGANTHI A. 31. Date filed (Month, Day, Year) FEB 1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ 1:08 P M Eckert Raymond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium 1911 Knollton Road 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Days 1 🛛 M 2 🗆 F Months Hours (Month Day Year) 216-20-6680 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 XNo Timonium Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21093 U.S.A 1911 Kn<u>ollton Road</u> Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Never Married 2 ☐ Married Completed by Maryland 21215-0036 filed within 72 hours after If Yes, Give WW II 1 Yes 2 No Specify 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Telecom Industry Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event ျ Amelia Roeseke Eckert Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 Baltimore, Maryland <u>3140 Fait Avenue</u> Jeffrev Combs Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 2-18-2011 Timonium Memorial Gardens Signator of Tree Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Road Towson, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repiratory arrest, shock, or heart failure. List only one caus pleach line. Approximate Interval Between Onset and Death Immediate Cause (Final Modse Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (of as a sonsequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached t g Unknown g Unknown Division of Vital Records, P.O. significant conditions contributing to death but not resulting in the Part II. Oth 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 X No 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 124

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Yea

4

11-00891 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Ermer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar
1. Decedent's Name (First, Middle,Last) Reg. No Physician/ 2. Date of Death Month Medical Examiner 1240 hrs Richard Ermer February 1, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 339 S. Conkling Street 2nd Floor Baltimore 5. Social Security Numbeunk 6 Sex **Funeral** 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) unk Director Davs Months Hours 1 X M 2 F 61 lay 6, 1949 Usual Residence of Decedent 10a State 10b County 10c City, Town or Location 10d. Inside City Limits or 28a-f show MD Baltimore 1 Yes 2 X No items 23a or 28a-f shoust be notified at once. after death with the Maryland Directo 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21224 USA 339 S. Conkling St; 2nd floor Funeral 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married Yes 9 If Yes, Give Year Widowed 4 Divorced Specify: White ges 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.

If item 27 is marked other than "natural", 1 Yes 2 X No specify. Š r Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Unk) 16b, Kind of Business/Industry Unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unkFrank DeSantis - landlord 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If i crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 9 Signature of Funeral Service ROTALO 22. Name and Address of Facility State Anatomy Board S. Wade, Director 655 W. Baltimore St; Baltimore, MD 21201 art I. Enter the disease, or Physician /Medical ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and Death Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Exam (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Chronic Obstruvtive Pulmonary Disease 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of certificate has performed death? Yes 2 ✔ No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes ER/Outpatient 3 DOA 2 27 Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending To the Funeral Director: 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. February 3, 2011 pleted cause of death (Item 23a)

Registra

Pamela E. Southall, MD

2 Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me g913 3-7-11 vt
State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1125A M Robert Earl Evans, Sr. abs vare 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) | Time 30, N/Atool 8 altimuse 9. Birthplace (State or Foreign Country)
1928N. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🔀 M 2 🗆 F 82 Director 217-20-9661 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits artment of Health and Mental Hygiene.
ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov
injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County hours after death with the Maryland Director 1 XYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 5315 Wabash Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: SpecifiBlack 3 X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 l Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel 8th grade Tender Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Gertrude Jones James Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 5315 Wabash Avenue Baltimore, Maryland 21215 Sharon Newman/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/16/11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet. Cem. Dwings Mills, MD 22. Name and Address of Facilithatman-Harris Funeral Home any inj 21. Signature of Funeral Se Reisterstown Rd Baltimore, MD 21215 5240 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Cou Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ste 3 Sequentially list conditions CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence a Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 1 ☐ Yes ≥ L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9,5 Sten 2 X/No 1 🗌 Yes 3 Probably 4 Unknown been si pestin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy perform 2 No Jenes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 X Yes 2 W No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Deatl 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider After 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signa 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State FEB Registrar

Krowy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February Day 2019 12:50A M Getzandanner, William Harry 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Walkersville 75 Main St. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1 🕱 M 2 🗆 F Days Hours Nov. 27, 1943 67 219-44-2622 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 No Walkersville Frederick Maryland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? U.S.A. 21793 75 Main St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2 X Married 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Wldowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) road construction surveyor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Caroline Elizabeth Grove Harry William Getzandanner Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walkersville, MD 21793 <u>Judy Getzandanner/ wife</u> 75 Main St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Hill Cemetery 2/11/2011 nr. Woodsboro, MD 21. Sig tu of Foreral Service Licen 22. Name and Address of Facility Hartzler Funeral Home m Woodsboro, MD 21798 404 S. Main St. 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
MONTHS - (EARS) Immediate Cause (Final RENAL METASTATIC disease or condition resulting in death) Due to (or as a consequence of): Caque itially list conditions, Due to (or as a consequence of): cause of death? 4 Unknown y findings available ☐ No

Ph_sician/ Medical Examiner Completed by Physician/Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

or 28a-f shov

Director

Funeral

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Completed

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be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at

and Mental Hygiene. is marked other than

permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once.

traumatic

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit signed by the After this certificate 24 hours after deat

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

edical Examin	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence of): d	
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
	1. DEEP VEIN T	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Rrobably 4 Unknown
Completed	1. HYPERTENSIO 3. DIABETTS N		24a. Was an autopsy performed 1
Be	25. Was case referred to medical	26. Place of Death (Ch	heck only one)
10 E	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence 6 □ Other (Specify)
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred
	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, death occured at the time, date and place iner: On the basis of examination and/or investigation, in my opinion, death occurre se Practioner: To the best of my knowledge, death occurred at the time, date and	ed at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

within 2

29b. Signature and title,

31. Date filed (Month, Day, Year)

SUITE #

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS

32. Registrar's Signature

29c. License number

Ba) (Type, Print) S. Taimur

061961

FREDERICK

29d. Date signed (Month, Day, Year)

02-10-2011

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar	-	artment of F tificate of L			giene Reg. No.	2011	04066
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last, Rebecca M.	Guthrie				2. Date of De February		2011 Year	3. Time of Death 9:46 P. M
	Examir		4a. Facility Name (if not institution, give s 3716 Evergreen Avenue	,	_	4b. City, Town, or Baltimore	Location of Death		4c.	County of Death	
B	Funeral Director		215-78-7170	7. Age (In yrs. 50 50	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 03/10/1	th 960	9. Birthp Count	lace (State or Foreign ry) MD
	/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Loc	ation				10	Od. Inside City Limits
	28a-i	Director	MD N/A	В	altimore						1 🛛 Yes 2 🗌 No
	with the 23a or ist be r	eral D	10e. Street and Number 3716 Evergreen Avenue			10f. Zip Code 21206			10g. Citiz	zen of What Coun	try?
	death r items iner mu	/ Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Vas Decedent of H	ispanic Origin? (Spe In, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - America Black, White, e	
9036	rs after iral", o Exam	ed by	1 🔀 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.	1	☐ Yes 2 🛛 No	Specify:		8	Specific	ite
5-0	2 hour	plet	15. Decedent's Edi (Specify only highest grad		16a. Deced	ent's Usual Occup	ation during most of work	ing	16b. Kir	nd of Business Ind	
727	ithin 7 iene. r than the M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)) NOT use retired) n = Rehahi l ii	itation Cour	nselor	Stat	te Of Mary!	and
br	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)		1.000.010	. Nakasii	18. Mother's Nam				
ylaı	Menta Menta narked	မ	Ronald		Gi	uthrie	Leverne				Saunders
Baltimore, Maryland 21215-0036	permit. Pige 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ. Jacqueline C. Adams, P				Avenue, Bal				ode)
ore	ge 1 au nt of H :: If iter or oth	1	20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ I	Removal from State		atory or other place	:e)	Date		cation - City or To	
ij	nit. Prartme ortari injur.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	11111		. Corporat Name and Addres		/2011 5305 Ha	Tows	on, Maryla Road	nd
ä	permi Depar Impo any ir		Janbrarell 1	Folan	م_ا	name and Address	uck, Inc.			ryland 21	214
	hysician/		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Stage	4		g, such as cardiac d		rest, - CLN (er 3	Approximate Interval Between Onset and Death
	Medical Examiner			Due to (or as a cor seq	uence of):			0			
	sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a conseq	uence of):						
	cate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
097	ate be rhysicia the bur	edical	•	d							
	requires that the death certifics been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fet: 4 ☐ Pregnant at time of	al death 3 🗌	Ectopic pregnance Other (specify)	у		2	3d. Date of delive	ry Day Year
ls, P.O.	uires that the signed by ald be detailed.	by	Part II. Other significant conditions cor	tributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.	\ _		e contribute to the	e cause of death?
Records,	law has	Completed						24a. Was a autop perfo		24b. Were autop prior to con death?	sy findings available apletion of cause of
[a]	sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?	ospital:			ace of Death (Check		110		
<u> </u>	Physic this cral din	5. To	1 Yes 2 2	1 Inpatient 2 I	ER/Outpatient	3 DOA Othe	4 U Nursing Ho			Other (Specify)	
ouo:	ath. r: After	icate	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work		28d. Describe h	ow injury	occurred	
Division of Vital	al or Atters after de I Directo	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		et, factory, office		28f. Location (S City or Tow		Number or Rural I	Route Number,
ر ت :	of the Hospital or Attending Physician: In the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examine	clan: To the best of my know er: On the basis of examinatio Practioner: To the best of m	n and/or investi	gation, in my opinio	n, death occurred at	the time, date a	nd place, a	and due to the caus	se(s) and manner stated.
	Vithir Comp	-	29b. Signature and title of certifier			29c. License	number		- ',	signed (Month, D	
	/ 1		20 Name and add to		00-1/7		4841		4	11/11	
	5V		30. Name and address of person who co	· ·			Rosedale. I	VD 21237			
E	Stat Registra		31. Date filed (Month, Day, Year) FEB 1 4 201	32. Pegistrar's Signa		aked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day OS Year GAVIS Physician/ **JEROME** Month 7:00 PM OZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE UNION MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X**□ M 2 □ F Months Hours b6*M*IB/IBZ8 CT82 Yrs. Director 088-20-4064 Usual Residence of Decedent 28a-f shov 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director BALTIMORE Yes 2 No MD N/A10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a Funeral USA 21210 111 HAMLET HILL RD., UNIT 111 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. Specify 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PROFESSOR OF ÉNGINEERING **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ IRVING GAVIS GOLDIE PAISNER 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 HAMLET HILL RD., UNIT 111 BALTIMORE, MD 21210 RUTH GAVIS / WIFE 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b, Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, BALTIMORE HEBREW CEM. 02/11/2011 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition massive isc Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter on denying Due to (or as a consequence of) Exami and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an cate has I page 2 s autopsy performed? Yes 2 N certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ဂ္ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🛮 Natural 5 \square Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 02/08/11 Owens. NPI: 1381414754 nacy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -Union Memorial Hospital 2018. University Plany, Baltimore, MD 21218 racy 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04068 State of Maryland / Department of Health and Mental Hygiene 🤈 State
Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Physician/ 2011 2011 0417 AM Sheila Grace Haynie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House WESTMINSTER Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Yea 78 Director 144-24-9221 Dec 932 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director Marriottsville MD Carroll 1 ☐ Yes 2 🌡 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21104 USA 1601 Brangles Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) health care medical secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Winifred Frank Henry James Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Brangles Ct., Marriottsville, MD 21104 Mr. Guyfred A. Haynie (spouse) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 2-16-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige of aight o P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Preunonic Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖎 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 114 Business Center Dr. Reisterstown MD21136

Registrar

State

31. Date filed (Month, Day, Year)

FEB

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month D2 Clifton James 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Jewn, or Location of Death Esther's Place Bultimore 2802 Pinewood Ave Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Min. 219-26-5728 1 XM 2 🗆 F Months Hours 73 21 1938 MD Tan Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2802 Pinewood Ave. 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 No Black, White, etc 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 😾 No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Kendicott Corp Mold Man N/A17. Father's Name (First, Middle, Last) Clifton H. James, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Mildred Dockery 19a. Informant's Name/Relationship (Type, Print) Esther James/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1740 N. Bond St. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) C. Zion Cem 1 X Burial 2 Cremation 3 Removal from State 2/14/11 Mt. Lansdowne, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly 21. Sign Jure of Funeral Service Licensee $^{22.\,\,\text{Name and Address of Facility}}$ Beverly D. Cromartie F/s 2700 Edmondson Ave. Balto., MD 21223 Part #. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ender, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis lays disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CVA = aphasia, dementia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown seizure disorder 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 NOther (Specify) assisted live 1 🔲 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of

physician and s the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 nding p signed by the atte s certificate has b lirector, page 2 sl this

Examiner Physician/Medical þ Completed æ ျ Certificate: Medical

1 🛛 Natural

Accident

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

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ıral", or items 23a oı Examiner must be

permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane.

Physician/

Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral I

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Completed

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death v

within 24 hours after death.

To the Funeral Director: After to completed filled in by the funer.

3 ☐ Suicide 4 ☐ Homicid		28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		ocation (Street and Number or Rural Route Number, ity or Town, State)
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier			29c. License number	29d. Date signed (Month, Day, Year)

28c. Injury at work? 1 ☐ Yes 2 ☐ No

R16229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28d. Describe how injury occurred

Eastern 4940 Holden

31. Date filed (Month, Day, Year) 32. Registrar's Signature 4

5 Pending

Investigation

State

Registrar

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 8, 2017 3:58 A M Yuk Kwan Jim Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson 5. Social Security Numbe If Unde If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1960 Months Hours Hong Kong 1 🗆 M 2 💢 F Director 213-39-5876 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Rosedale Maryland| 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21237 Permanent Resident 7618 Chesterfield Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 14. Race - American Indian. Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Chinese 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mei Jim Jsoi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 <u>7618 Chesterfield Way Rosedale, Ma</u>ryland 21237 Pek Tin Tong Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State 2-12-2011 4 ☐ Donation 5 ☐ Other (Specify) Towson Hilltop Service Corp . Signatur NF neral Serv 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Licensee Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To I 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cer Tying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

N. Chail

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., g912, 02/14/2011 dhb.
Certificate of Death

Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ errick Lloyd Johnson Month Day 5 5:31 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Samaritan Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) 27 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day **Funeral** 9. Birthplace (State or Foreign Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director BUHINDRE 1 Yes 2 ☐ No 10e. Street and Number 1558 Sherwood 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ 21215-0036 1 ☐ Yes 2 XNo Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOF use retired) V/Seconday (0-12) College (1-4 or 5+) nutactun Be Maryland 17. Father's Name (First, Middle, Maiden Şurname) other's Name (First, Middle 2 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number WITE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) tark 21. Signature of Funeral Sarvice License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician Status epile disease or condition resulting in death) hours Medical Due to (or as a consequence of Examiner hours epsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as consequence of) The law requires that the death certificate be executed Immuno d ciencu eavs Human attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of). nal Physician/Medical Yeavs Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month been signed by the a should be detached t Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ rension 2 No 3 ☐ Probably 4 ☐ Unknown Completed I ransplant 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES February 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 , Balti move Zaki Abou 5601 Raven Blud Lahr Loch 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Feb. Physician/ Mary C. Kirby 1:18 A.M 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Carroll Hospice-Dove House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Day, Year, Country) 1 □ M 2 😿 😿 Director 69 213-42-4113 Usual Residence of Decedent shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Tes 2 No Carroll Westminster Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21157 14 North Church Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 😾 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Travelers Insurance Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Davis Otway Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Courtney O'Neill 14 North Church Street Westminster, MD 21157 Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory Feb. 11, 2011 Winfield, MD 22. Name and Address of Facility
urrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784
Approximate neral Service Lice 21. Signatur of The cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate 23a. Par 1. E ter the disease, or complications time Interval Between Onset and Death sh ck, a heart fallu Imme iate cause (Final dise se of condition resulting in death) heart failure. List only one cay Physician/ Medical (or as a consequence of Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ned by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death Yes been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s 1 Yes 2 No After this certificate 25, Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be WPANED Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 Pending ☑ Natural 1 ☐ Yes 2 ☐ No after death. Director: Af Accident Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) d title of certifier License number 29b. Signature 3 (Month, Day, Year) 1 4 2011 State

DHMH 17 Rev 7/2009

Registrar

11-01084 George Lymas

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of use Pit		anner of Dea	th		28a. Date of (Month, D	Injury Pay.Year)	28b. T	ime of In	jury 2	8c. Injury	at Work	? 2	8d. Descri	be how ir	njury occum	ed		
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Division o spital or Attending Jours after death. neral Director: After filled in by the fune] ₄ =	Suicide Homicide		ermined	(Specify)								or row	n, State)				
fospi 4 hou funci		Certifier .	Certifying F	Physician:	To the best	of my knowle	dge, deat	th occurr	ed at the	time, dat	e and pla	ce, and c	lue to the c	ause(s) a	and manner	as state	ed	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as leading 10 or the funeral director, page 2 should be detached for use as leading 10 or the funeral director.	one)	2	Medical Ex	aminer: Or	n the basis of	examination	and/or in	vestigati	on, in my	opinion,	death occ	curred at	the time, d	ate and p	lace, and d	lue to th	e cause(s)	
To To To	29b. S	signature and	title of certif		d manner sta	tea.			290	License	number			290	I. Date sign	ed (Mo	nth, Day, Year)	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ 5:00P M Vacnzi February Lerp 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Randallstown Northwest Hospital-Seasons 8. Date of Birth June 21, 1914 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 🗆 M 2 😾 Months Hours Baltimore 217-14-2094 96 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10b. County 10c. City, Town or Location Director 1 Yes XX No Randallstown Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21133 Funeral 3607 Chapman Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give White Completed 3 → Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home 12th Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Alice Phelps Samuel Edward Whitlock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2440 Alees Drive New Windsor, MD 21776 Edward S. Lerp, Jr. Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1XXBurial 2 Cremation 3 Removal from State Holy Family Cemetery Feb. 15, 2011 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licens 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory
1212 W. Old Liberty Road Winfield, M 21784 23a. Firt 1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or high artifailure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Caus (Final Physician/ End-Stage Dementia disease condi on resulting in Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) How pict 1 Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

758 CHAP OWNEM. D

N. S. Rajapakse, M. O 31. Date filed (Month, Day, Year)

FEB 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2838 Smilh M

32. Registrar's Signature

Back

- 5-203

DO057465

- Baltimore, MD-21209

2/12/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 1 per pHYS, G912, 2/24/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Caroline Adaobi Mbanusi 2 Date of Death Physician/ FEBRUARY Day 1 20 TI ADAOBI MBANUST 12:48 AM CAROLINE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 9. Birthplace (State or Foreign Social Security Number If Under 1 Year I If Under 24 Hrs. 8 Date of Birth 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛚 Hours (Month, Day, AUGUST NIGERIA Director 65 NONE Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S GREENBELT 1 ¥ Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20770 NIGERIA 9136 SPRINGHILL LANE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 2nd ENTREPRENEUR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
NWANYIEKE ILOERIKE 2 OKIJBO IDELI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9136 SPRINGHILL LANE GREENBELT, MARYLAND 20770 JUIANA OKAFOR/DGT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2011 LAGOS, NIGERIA FAMILY PLOT 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. . Signature of Funeral Service Licenses LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 7474 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition 2000 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled by the effection and the second transitthat initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician a d be detached for use as the burial-Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Historyn 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 0 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Was case referred to m 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide Could not ace of Injury - At home, farm, street, factory, office ilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) det ned Medical Certifying Physician: o the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signaty 29c. License number (Item 23a) (Type, Print) 9 31. Date filed State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 1:00 p M Mules Cornell 02 0 2011 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner na 1418 N. Decker Avenue Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Year) Hours Months 247-56-8207 1**X** M 2□ F 05-01-Director S.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Functions 200. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☐ No Director more 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Decker USA 2121 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker UNKNOWN 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phil Myles ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maria Little-Daughter 1418 N. Decker Avenue Balto,MD 21213 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition K Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) King Memorial Pk 2-14-2011 Randallstown, MD 21. Signature of Fun Service Licenses 22. Name and Address of Facility March East F/H E. North Avenue Balto, 21202 1101 - Lucker Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. days **Physician** Hypertensive /Medical Due or as a consequence of): Examiner pentensia S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to o as a consequence of) Examine Oh Stru Aronc and the burial-trai Due to (or as a consequence of) physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 10054000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bles Below Edison Family Health Center 3120 Erdmon Ave, But MD21213 EVICA mu 32. Registrar's Signature

State Registrar

completely

the within 2 Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 25^{uay} 201^{Year} 2:25 Α Edna Mae Morris Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth June 28, Year 194<u>6</u> Days 1 M 2 X F Maryland Vrs Director 216-44-1657 64 Usual Residence of Decedent or 28a-f show notified at 10a, State 10h County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Harford MD Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? Funeral USA 21014 12 Glen Gate Court death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? Black. White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) grocery clerk food industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Lee Davis Ora Lee Testerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Greenlund - sister 22 Glen Gate Ct; Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature | Funeral S 22. Name and Address of Facility State Anatomy Board *x*ector 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician, disease or condition resulting in death) SOFT TISSUE SARCOMA Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate care. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death g Unknown 1 ☐ res ∠ u Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 **K** No Other: 1 Tes 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 \square Pending injury work? Accident Suicide Investigation within 24 hours after deat To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

а.п.

JANUARY

MORRIS

2300 DULANEY VALLEY RD.

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIĖ JONES,

31. Date filed (Month, Day, Year)
FEB 1 4 2011

201

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ February 4, 2011 6:07 Рм Melodie A. Messerall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil E1kton Union Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Aug 24, 1 □ M 2 🖾 F Hours T949 Maryland **Director** 61 218-52-0840 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 X No Northeast Cecil MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral USA 21901 73 Pincecone Drive 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. white ģ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) hospitality housekeeping 0 11 Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 73 Pinecone Drive; Northeast, Maryland 21901 . Page 1 and 2 st tment of Health a tant: If item 27 is Darla Foster - friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot Ronald S, Walle 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Non Hodgkins Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Immun Sequentially list conditions Examine ri any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Human Imma death certificate be executed the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached f 2 No g Unknown 1 ☐ Yes 2 L g ☐ Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? \$ Neutropenia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law autopsy director, page 2 performed certificate | Failure 1 Yes 2 No Respirator 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 Annpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending Natural work' 1 🗌 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number P0065013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) FEB 14

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.
Physicia	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1520 brs
Medical Exami	ier	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		Sinai Hospital Baltimore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		212-58-4173 1 M 2 MF GO Yrs. 8-18-1950 Country) VA
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
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ne Maryland or 28a-f show fied at ooce.	rect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the 23a or		13 29 Win Ston AVENUE 21239 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
eath w	Funeral Director	1 Never Married 2 Married 2 Married 2 Married 1 Yes 2 No
after d	J.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:
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336 thin 72 re. than edical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Courselor Rosewood Centrer
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	ဦ	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
2121; vuld be fil Mental F marked	Be	JOHNT. Summers 19a. Informant's Name/Relationship (Type, Pr. 1) 19b. Mailing Address (Street and Number or Rural to Number, City or Town, State, Zip Code) 1239
MD 2 12 shou th and N 127 is n umatic	ှု	Sophronia T. Parker 1927 Wood howne Ave. Patto MD
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28s-f shown other traumatic event, the Medical Examiner must be notified at occe.	ľ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State Crematory or other place)
Pages nent of		4 Donation 5 Other Specify: (Sees your (renator) 2114/2011) Baltimore, ND
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		21. Signatore of Funeral Service Licensee A sme and Address of Facility & Truseral Services
Physician	-	23a! Part I. Enterfule disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease Between Onset and Death
.xammer		or condition resulting in death) Due to (or as a consequence of):
	ě	Sequentially list conditions, if any, leading to immediate b Due to (or as a consequence of):
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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760, cate be executed physician and the burial - transi	Medical	UNPENDED AMENDED
876 tificate ng phy as the t		F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 22b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year
Box 687 he death certific the attending p	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown 9 Unknown
O. B.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
, P.6 res that signed be det	d b	diabetes mellitus
v requi	Sete	24a. Was an autopsy findings available prior to completion of cause of
Recc The lay cate ha	Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Recient The certificate ector, page	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other:
of Viing Physi	유	Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
OD C ending ath or: Af	텵	Natural 5 Pending 1 Yes 2 No
Division of Vital Records, P.O. ra lor Attending Physician: The law requires that the safter cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detable.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
D ospital hours hours y filled		4 Homicide (Specify) 29a. Certifier A Contribution To the heat of my knowledge death occurred at the time date and class and the to the cause(s) and manner as stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To Will	₹	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Tanute (Vulhall, ML) O.C.M.E. February 10, 2011
V		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
St	ate	24 Bayesta day att. Dan Vand. 122 Decisitative Signature
Regist		FEB 1 4 2011 Denue S. Gare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2011 James L. Misner 10:30am 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 9533 Keys Chapel Rd. Union Bri<u>dg</u>e Frederick Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Davs Hours Min. Oct. 5, 1955 200-46-6409 55 Pennsylvania Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9533 Keys Chapel Rd. 21791 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 1 XYes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗎 Divorced Specify: White Year or Dates. 1973-77 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) artist <u>art in wood</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond L. Misner Joyce Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A.D. Misner/wife 9533 Keys Chapel Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 2/11/2011 Sykesville, MD Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home Jarine a 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate

Ph_sician/ Medical Examiner

physician and the burial-trans

the attending physician hed for use as the burial

Important: If it any injury or o

Physician/

Medical

Director

Funeral

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"natural", or items 23a or 28a-f sho

27 is marked other than "natu traumatic event, the Medical

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by Medical Certificate: To Be

or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached?

Division of Vital Records, P.O. Box 68760

Cause (Disease or iinjury that initiated events c.					
resulting in death) Last	Due to (or as a conseq	uence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregni 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectop	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions cont	ributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
				1 Yes	2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1 □ Yes 2	
25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)	
1 ☐ Yes 2 🔀 No	spital: 1	ER/Outpatient 3 🗆	DOA Other: 4 Nursing I	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
(Check 2 L. Medical Examine	r: On the basis of examinatio	n and/or investigation,	at the time, date and place, a in my opinion, death occurred curred at the time, date and pla	at the time, date and place	ce, and due to the cause(s) and manner stated
29b. Signature and title of certifier	·	2	9c License number	204 [Pata signed (Month Day Year)

0032245

Amy Jones

State Registrar

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Wayne Morris Myers Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year 1 X M 2 □ F Months Days Hours Min. 69 Maryland **Director** 216-38-4370 1941 Apr. Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Carroll Westminster Maryland 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 2200 Uniontown Rd. 21158 U.S.A. items ; 72 hours after death 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ğ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) comptroller of finance tool mfq. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Raymond DeBerry Myers Elizabeth Catherine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary J. Myers/ wife 2200 Uniontown Rd. Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 2/14/2011 Keysville, MD 21. Significant of Funeral Service Licensee (My Danne). 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final MUUTI-OREAN SYSTEM ALLURE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the a 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD ZOO MEMORVAL AVENUE, WESTMINSTER,

32. Registrar's Signature

D30263

2-11-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 0110 PM February Ann Mathis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Lorien Mt. Airy Airy 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Days 1 M 2 XF Months Hours Director 0klahoma 447-34-8946 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Howard Woodbine 1 Yes 2 X No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21797 15055 Old Frederick Road USA items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ٥, þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white "natural" 3 XWidowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 amy injury or other traumatic event, the Meone. Elementary/Seconday (0-12) College (1-4 or 5+) food service cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Jeffrey Martha June 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Harbin (daughter) 15055 Old Frederick Rd., Woodbine, MD 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🏝 Burial 2 □ Cremation 3 □ Removal from State Seal Family Cemetery 2-14-11 Sunshine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Darge Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Me disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Feta 355.
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination allows investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 11 30. Name and address of person who completed carse of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Antoinette Phelan 9:53 FEBRUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2x Months Davs Hours June 13 1918 New York 92 100-01-5694 Director Usual Residence of Decedent shov 10d. Inside City Limits 10b. County 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouny or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No Maryland Towson Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21204 8021 Strauff Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Agnes P. McNeeley James F. Milde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8021 Strauff Road Towson, Maryland Frances Phelan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth Burial 2 Cremation 3 Removal from State 2-19-11 4 Donation 5 Other (Specify) Holy Cross Cemetery New York, NY 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatury of Fundal Service Licensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final MYOCARDIAL INFACTION ∲nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions Examiner Due to (or as a consequence of) in any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Day Pregnant at time of death Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown AORTIC STENOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 🔀 No Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D 64300

10^X \

DHMH 17 Rev 7/2009

Registrar

7601

OSLER DRIVE,

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar's Signature

COURTNEY ROSENTHAL,

31. Date filed (Month, Day, Year)

14

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh 9912 2-17-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 8, 2011 Lucretia Pi 11 6:30 РΜ Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 5330 Midwood Avenue Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. 02-07-1922 Director 215-30-5778 Estonia 89 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Baltimore 10a. State 10b. Count 10d. Inside City Limits Director N/A Maryland 1 Yes 2 □ No 10f. Zip Code 21212 Oe, Street and Number 10g. Citizen of What Country? 5330 Midwood Avenue Funeral LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic avent. If Yes, Give Year or Dates White 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Manager Bonding Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nikolai Raid Hermine Putt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Urve Kiik - Daughter 2500 Spring Wood Lane Richardson, TX 75082 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02-10-2011 Hillton Service Corp. Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Full rail Service 22. Nams and Address of Facility nc 5305 Harford Road Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a con equence of): Examiner (oronae Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the a g 🗌 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Wills 5601 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 1:25PM meer Medical vn, or Location of Death 4c. County of Death Examiner 'im or If Under 1 Year te of Birth Birthplace r Foreign Age (In **Funeral** Sex 1 M 2 □ F Days Months Yrs. Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 ☑ Yes 2 ☐ No more 10g. Citizen of What Country? 10e, Street and Numbe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life_DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ٥ 19b. Mailing Address (Street and Number of Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Rural Route Number Baltimore Koad MD queline Johnson (Sister 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 2-21-11 4 Donation 5 Other (Specify) Greenmount 21. Signatur of Funeral Service Lansee Valland and Address of Facility
Yallann C Greene Funeral
5157 Bathmore Nating Natina 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and leith Immediate Cause (Final repato cell ular carcinoma Physician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a considence of): Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Yes q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes ivision of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Tyes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) DICE Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 who completed cause of death (Item 23a) (Type, Print)

Richey Hospice 838 N. Entaw St 30. Name and address of person Hospice MD 150 31. Date filed (Month, Day, Year) State 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 06/0A BARBARA KO BINSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Examiner** BALTIMORE BON SECOUNS HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours Ju 1 9 1 9 6 5 Country 212-80-1140 45 **Director** MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10b. County City, Town or Location Baltimore 10d. Inside City Limits **Funeral Director** N/A 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2711 Edmondson Avenue 21223 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.

of Health and Mental Hygiene.

If item 27 is marked other than "r

or other traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) The Villa Nursing Assistant 12th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Robinson Rosa Hendrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Everett M. Lunn/Husband 2711 Edmondson Ave. Balto., MD 21223 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important; If ite
any injury or ot
once. Burial 2 Cremation 3 Removal from State King Mem ¼ark 2/11/11 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beverly D. Cromartie F/S2700 Edmondson Ave. Balto., MD 21223 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final AUREUS Ph_sician/ STAPH SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** DISEASE STAGE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DISEARE IM VNODEFICIENCY as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 24 No
9 Unknown 5 Other (specify) Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 LUNG. CANCER CELL NON SMALL 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed RENAZ DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy ISCHEMIC 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes Certificate: To 1 Nipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. con who completed cause of death (Item 23a) (Type, Print) 22 SOUTH SITEIN GEUD ALTIMORE 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2 5 W CICUMBY /Medical 4a. Facility Name (If not institution, give street and number)

Franklin Some Hosp 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Beltmore MI Roscanle Franklin HOSPUTZ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M XX F 216-36-7070 Yrs. Sept. 4, 1939 Maryland 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 27 is marked other than "natural", or Items 23a or 28a-f ahow traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21222 66 DelRio Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: ichmond Maryland 21215-0036 Specify. à 3 Widowed 4 Divorced White and Mental Hygiene.
Is marked other than "natural". 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Angela Woods Howard Hardy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 21237 28 Talister Court Rosedale, Maryland Stuart K. Richmond, IV (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Moreland Mem. Park Cem. 2/16/11 * 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave, Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andiopulmon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☑ No signed by the atte 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha 2 No 1 Yes Division of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To this After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation thours after death.

-uneral Director: A
ely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number by sporz MAD Felo 68682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore MO, 21337 31. Date filed (Month, Day, Year) Uperos, 32. Registrar's Signature State FEB 1 4 2011

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2011 11:30 P M Skovira Marie Kathryn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice <u>Timonium</u> 9. Birthplace (State or Foreign Country)
Pennsylvania 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8 Date of Birth **Funeral** Days Hours 1 🗆 M 2 💢 F Months Director 169-14-4237 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2X No <u>Parkville</u> Marvland Baltimore 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21234 U.S.A. 2612 Rader Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes : 2 **X**Vo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dawnorowicz Malachowski Emilia Casimir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Maryland FEBRUARY 2612 Rader Avenue <u>Dorothy Sacker</u> Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗔 Removal from State Hilltop Service Corp. 2-14-2011 4 ☐ Donation 5 ☐ Other (Specify) Towson Maryland Synal ye of Fu 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland a 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last KATHRYN SKOVIRA Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗶 Other (Specify) HOSPICE 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 24 hours after deat Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number 2011

Registrar

State

JACKIE JONES,

31. Date filed (Month, Day, Year)

FEB 1 4 2011

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

Stephen Irving S		1- For State	tate of Maryla		partment of Certificate of		d Mental H		eg. No. 20	11 04089	
Physicia	ın/	1. Decedent's Name (First, Mid						2. Date of Dear	Day Year	3. Time of Death	
Medical Examir	ier	Stephen Irving 4a. Facility Name (if not institut		nber)		4b. City, Town, or	Location of Death	February 9	4c. County of		
N		2002 Cromwell Bridg				Cockeysville			Baltimore		
Funeral Director	1	5. Social Security Number			rs. last birthday)	If Under 1 Year Months Days			ì	Birthplace (State or Foreign Country) 4	
Sirector		214-78-9233 Usual Residence of Decedent	1 M 2 F	47	Y	rs.		Apr. 1	5, 1963	countryMaryland	
' any	İ	10a. State 10b. County	,	10c. 0	City, Town or Loca	ation				10d. Inside City Limits	
land f show	ច្ច		imore	I	Towson				0g. Citizen of Wha	1 Yes 2 No	
e Mary or 28a-	Director	10e. Street and Number 7606 Far Hills	Drivo			10f. Zip Code 21286		[USA	at Country?	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show mastic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Dece			/as Decedent of His			cify Yes or No- 14. Race - American Indian, Black,		
death or item	Funeral	1 Never Married 2 X	1 Yes	2 X N	o If	Yes, specify Cuban					
rs after nral", miner	ã	3 Widowed 4 D	ivorced If Yes, Give Year or Dates:		1 16a Decede	Yes 2 X No		Specify: white work done 16b. Kind of Business/Industry			
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2121 2121 Juld be fill Mental F marked ic event, j	To Be	Irving A. Smit 19a. Informant's Name/Relation	Ship (Type, Print)		19b. Maili	ng Address (Stree				n, State, Zip Code)	
MD d 2 sho lth and a 27 is numati	7	Nora K. Smith	/ wife			Far Hill					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal fro	m State	crematory or			Date		City or Town, State	
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other		I		Service C		15/2011	Towson,	MD 050 York Road	
Bal Bermi Depar Impo		21. Signature of Fundral Salvi.	View			uck Towso		al Home.		Cowson, MD 2120	
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	П	or condition resulting in death)	Due to (or as a b. Hanging	consequen	ce of):						
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ivision of Vital Records, P.O. or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by I in by the funeral director, page 2 should be detach	\vdash	27. Manner of Death	28a. Date of Month FOUND:	of Injury Day,Year)	28b. Time o	· ' · · · · · · · · · · · · · · · · · ·	ry at Work?	28d Describe Subject fou	how injury occurre	ed	
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Division tal or Attendi rs after death. al Director: A	Certification:		uld not be	Woods	At nome, laim, su	eet, factory, office b	odilding, etc.	or Town,	State)	, Cockeysville, MD	
Hospi 24 hou Funca		29a. Certifier 1 Certifying	Physician: To the besi	t of my know	wledge, death occ	urred at the time, da	ate and place, an	d due to the cau	se(s) and manner	as stated.	
To the within To the comple	Medical		taminer:On the basis of and manner st	f examination	on and/or investio			at the time, date		ed (Month, Day, Year)	
	2	29b. Signature and title of certi	(29c. Licens O.C.			February 10		
		30. Name and address of person	on who completed caus	e of death (Item 23a)						
5 V		Ana Rubio MD. A	ssistant Medical E	xaminer	900 W. Ba	Iltimore Street,	Baltimore, M	D 21223			
St. Regist		31. Date filed (Month, Day, Yea	32. Re	gistrar's Sic	nature						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05:50 ам 10 Stratos 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2702 Second Avenue Carnev Baltimore If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 👿 F Months Days Hours 215-28-4987 03/12/1926 **Director** Greece Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No MD Baltimore Carnev 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2702 Second Avenue 21234 items 2 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Heath and Mental I Important: If item 27 is marked of any injuy or other traumatic eve once. ပ Dimitrios Evdokia Kerasiotes Grafakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Bellfalls Way Nottingham, Maryland 21236 Bertha Boring, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 2/14/11 St. Demetrios 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUKEMIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or limitary) Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 Tho Į Day Month Vear Pregnant at time of death the funeral director, page 2 should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of D ath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Ratural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr SUIF E Parkville 2109 ITARFORD Rd 2123

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB

Physiciar Medica Examin JOSEPH SHAFFRON **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Pakent known as Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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		1 A Burial 2 4 ☐ Donation		3 ☐ Removal from St Specify)	ate		OV CEMETE		1/2011	I	BALTIMOR	RE, MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Surg shub 9:00A 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Months Hours 03/29/1919 Director 219-17-9086 91 KIEV Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director MD BALTIMORE BALTIMORE 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 6968 MARSUE DRIVE, #1A 21215 USA should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates T is marked other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) UKRAINE DEPARTMENT Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER OF PUBLIC WORKS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **JOSEPH** LISCHINER GUTNIKOV LEA .. Page 1 and 2 shou tment of Health and tant: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH LIPSKY / DAUGHTER 2 JESSIE COURT REISTERSTOWN, MD 21136 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of P
Important: If ite
any injury or ot
once. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 102/11/2011 OWINGS MILLS, MD 21. Sign a tire of Funeral Service Livinse SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final End. Stage COPD Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Just to for as a consecuence of cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 4 Pregnant Pregnant at time of death 2 No the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖭 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MSRajapahseM.D 00057465 2/10/11

Registrar

State

Barks

N S. Rajapakie, M.D. 2838 SMITA IN-5-203, Baltimore, MD. Z1209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

31. Date filed (Month, Day, Year)
FEB 1 4 2011

			_ For	State of Marylar				Mental Hygie	ene	01000
			State Registrar		Ce	rtificate of	Death	Reg	J. No.	04095
	Physici	on	1. Decedent's Name (First, Middle, Last	,		7		Date of Death Month	Day Year	3. Time of Death
	/Medi			Joseph	T.	Valuna		2	5 2011	9:36 am
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of De	ath
- griddin	-		4025 Cranston 5. Social Security Number 6. Se		. last birthday)	Balti If Under 1 Year	more If Under 24 Hrs.	8. Date of Birth	na	irthplace (State or Foreign
	Funeral Director			X ^{M 2□ F} 64	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10-5-1	2946	MD
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medicel Examiner must be notified at	햐	MD	na E	Baltim	ore				1 Yes 2 No
	or 28,	irec	10e. Street and Number			10f. Zip Code			g. Citizen of What C	Country?
	23a ust b	Funeral Director	4025 Cranston	Avenue		2122			JSA	
	tems ter m	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ✔ Divorced	1 ViYes 2 □ No If Yes, Give Year or Dates:		1 □Yes 🛣 No	Specify:		Specify: W	hite
21215-0036	hour tural	ed	15. Decedent's Edi		16a. Dece	dent's Usual Occup	pation	16	b. Kind of Busines	s/Industry
215	in 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of world)	king		
	d withii giene. er than	Completed	12th grade			Driver	F		Various	s Jobs _
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma		
yla	Men Men Marker Marker	ဥ	John Valunas					n Sokolo		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7) John M. Valuna				and Number or Ru s Avenu	ral Route Number, (City or Town, State MD 21	
	1 and Healt em 2	П	20a. Method of Disposition						Oc. Location - City of	
Baltimore,	permit. Pages 1 ar Department of Hes Important: If item any Injury or othe once.		1 Burial 2 ☐ Cremation 3 ☐	Removal from State		nsition (Name of matory or other plain Fores		4-2011)wings M	Mills, MD
Ħ	nit. Partme artme ortan Injur	11 1	4 Donation 5 Other (Specify 21. Signature of Funeral Service License			2. Name and Addre			Cast F/H	
B	permi Depa Impo any Ir	W 9	Mouth	K. m	70	1101 E.	North A		Balto,	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	ith. Do not en	ter the mode of dy	pg, such as cardiac	or piratory arres	st,	Approximate Interval Between Onset and Death
lan.	Physician	3 N	Immediate Cause (Final disease or condition	ine cause off each arie.	06	noVa	a 2011	lan C	2 Cerd	Onseiland Death
	/Medical		resulting in death)	a Due to (or as a conse	quence of):					
	Examiner	١, ١	Sequentially list conditions	b						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence oi).					
_	ficate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
8760,	be e sician buria				4					
687	ficate g physis the	edic		d					1	
Вох	Physician: The law requires that the death certific this certificate has been signed by the attending raid director, page 2 should be detached for use as	Physician/Medical	23b. was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		⊒ Ectopic pregnan	cv		23d. Date of d	
	e deal he att ed for	Sicis	in the past 12 months? 1 ☐ Yes 21 ☑ No	4 ☐ Pregnant at time of		Other (specify)			Month	Day Year
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Š,	ires the signe		Part II. Other significant conditions of	ommouning to death but not re	suiting in the t	nderlying cause gr	venin ranti.			Probably 4 Onknown
of Vital Records,	v requir	Completed by								
Rec	e law has ge 2 s	ם						24a. Was an autopsy performe	/ prior t	autopsy findings available to completion of cause of ?
<u></u>	lan: The rtificate hi		OF Mag ages referred to modical			· · · · · · · · · · · · · · · · · · ·	00 Pl (P	1 ☐ Yes 2	□ No 1 □ Y	es 2 □No
₹	yslcian: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 [T FR/Outpatie	nt 3 🗆 DOA Oti	hor:	th <i>(Check only ope)</i> Iome 5 Aesiden		necifu)
of	ding Phy h. After this funeral o	n: Ţ	27. Mann of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o			28d. Describe how		pecity)
ion	ath. r: Aft	atio	1		Injury]Yes 2 □ No			
Division	or Attendi after death. Director: A	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
Q	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer) i			
	Hosp 24 hor Fune stely f	Medical		ysician: To the best of my kr iner: On the basis of examin and manner stated.						
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	And marrier stated.		29c. Licen	se number	29	d. Date/signed (Mo	onth, Day, Year)
	- S - O		Mean	Lews	R	12	4621	67	2/8/2	2011
ļ			30. Name and address of person who d	completed cause of death (Ite	em 23a) (Type,	Print)	0.0	1/1-22	RAPL	1170 1111
1			J. Boatena	. 2411	W. 1	selve	dell	7774.	Due 111	2/21
			1 24 Data filed (Month Day Vacal +	1 22 Dehictror's War	oturo +					

State Registrar

DHMH 17 Rev 1/2001

			For State	State of Maryland / Depa	urtment of Health and M tificate of Death	ental Hygien	211:1:1:1:1:1:1:1:1:1:1:1:1:1:1:1:1:1:1	1
			Registrar 1. Decedent's Name (First, Middle, Last)	001	- Death	2. Date of Death	3. Time of Death	
	Physici /Medic		HURShell	le	ADE	FEBRUARY	6,2011 1:25mm	1
	Examin		4a. Facility Name (If not institution, give st	· ·	4b. City, Town, or Location of Death	* 4c	c. County of Death	
			The Johns Hopkins Hos 5. Social Security Number 6. Sex	Spital 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country) Un K	n
	Funeral Director			M 2 F 61 Yrs.	Months Days Hours Min.	(Month, Day, Year) Aug 6, 194	.9 Country)unk	
			Usual Residence of Decedent				10d. Inside City Limits	-
	the Marylan 28a-f show totified at	ō	10a. State 10b. County	10c. City, Town or Loc Baltimo			1¥ Yes 2 □ No	
	r 28a- notifie	Director	10e. Street and Number		10f. Zip-Code	10g. Ci	tizen of What Country?	\dashv
	th with 23a o st be		808 N. Belnord A	venue	21205	U	SA	
	r deat tems er mu	Funeral	CITE CONTRACTOR CONTRA		Vas Decedent of Hispanic Origin? (Spe f Yes, specity Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give 1 Year or Dates:	☐ Yes 2X No Specify:		Specify: black	ļ
21215-0036	2 hou atural cal Es		15. Decedent's Educ	cation 16a. Deced	lent's Usual Occupation unk kind of work done during most of worki		Kind of Business/Industry unk	ヿ
218	ithin 7 ie. ian "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+) unk	OO NOT use retired)	9		
2	should be filed with nd Mental Hygiene. marked other than matic event, the M		unk 17. Father's Name (First, Middle, Last)	unk	18. Mother's Name	e (First, Middle, Maide	en Surname) unk	\dashv
anc	d be f ental h ced ot	To Be	, , , , , , , , , , , , , , , , , , , ,					
Maryland	2 should be filed within 72 hours after death with the Maryland is and Merital Hygiene. Is marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ	e. Print) 19b. Mailin	ng Address (Street and Number or Run	al Route Number, City	or Town, State, Zip Code) un	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryis Department of Heath and Mertal Hygelens. Department of Heath and Mertal Hygelens "ratural", or items 23a or 28a-f sho Inportant: It item 27 is marked other than "natural", or items 23a or 28a-f sho any injuny or other traumatic event, the Medical Examiner must be notified at once.		Al Jones - frien					
Baltimore,	Pages 1 and 2 ment of Health a ant: If item 27 L ury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	inoval ironi state	sition (Name of Inatory or other place)	Date 20c. L	Location - City or Town, State	
ᄩ	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☒ Other (Specify) ☐ 21. Signature of Frineral		. Name and Address of Facility Šta	te Anatomy	v Board	\neg
Ba	Depa Impo any i		21. Signature of Funeral Licensee Ronald S. W.	ade pirector	655 W. Baltimore			
			23a. Part 1 Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not enti-	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between	
	Physician	ľ	Immediate Callifornial disease or condition		chemic cardio	morathy	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): Corenary Due to (or as a consequence of):	1 1.	,, ,		
		Jer	Sequentially list conditions, bif any, leading to immediate	Due to (or as a consequence of):	entary disease	e		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
ó	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
68760,	cate b	edical	d					
	eath certifica attending ph d for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy			23d. Date of delivery	
Box	es that the death cert gned by the attending be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)		Month Day Year	
P.O.	at the by the	Phy	9 Unknown		underlying cause given in Part I	23e Did tobacco	o use contribute to the cause of death?	-
ŝ	The law requires that the death certifica te has been signed by the attending phage 2 should be detached for use as t	i by	Part II. Other significant conditions con	tributing to death but not resulting in the u	indentying cause given in rait i.		2 ☐ No 3 ☐ Probably 4 ☐ Unknow	vn
Records,	w requi	Completed				24a. Was an	24b. Were autopsy findings availab	ole .
Ä	he law e has b age 2	ошо				autopsy performed? 1 ☐ Yes 2 🛣 N	prior to completion of cause of death? 1 □ Yes 2 □ No	л
		BeC	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
<u></u>	Physician: this certifica and director,	2	1 ☐ Yes 2 XNo	lospital: 1 Inpatient 2 ER/Outpatien		me 5 Residence		
uo	ding P th. After the funera	ion:	27. Manner of Death 1 X Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time o	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
VISI.	or Attending after death. Director: After I in by the fune	ertification:	3 Suicide 6 Could not be	28e. Place of injury - At home, farm, str			and Number or Rural Route Number,	
۵	afte Jin Dir	Cert	4 Homicide aeterminea	building, etc. (Specify)		City or Town, Stat		
	To the Hospital or within 24 hours after to the Funeral Diractor Completely filled in	edical		ician: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.				
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and marrier stated.	29c. Lipense number	29d. D	ate signed (Month, Day, Year)	
	F > F 0		A axander	Billew MD	Kes-0	00 Fe	BRUARY 6, 201	1
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	-			97
	Sta	to.	Hex and ev 31. Date filed (Month, Day, Year)	32. Registrar's Signature	600	NOTEN WOITE	St, Baltimore, MD, 2128	07
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 4 2011	Tenera B. park	/			

			For State C	of Maryland		artment <i>tificate</i>			nd Mental Hy	giene _{Reg. No.} 2 0 1	111195
			Decedent's Name (First, Middle, Last)				0.00		2. Date of De	ath	3. Time of Death
	Physicia Medic		William Michael Zimme						Februar	-	
	Examir	ier	4a. Facility Name (if not institution, give street and nun Stella Maris	nber)		4b. City, To	wn, or Lo oniu		Death	4c. County of De Baltim	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1	Year	If Under 24		th 9. B	irthplace (State or Foreign ountry) UNK
	Director		216-12-2934 Usual Residence of Decedent	89	Yrs.	Wortho		110410	April 1	y, Year) 1921 C	
	land show d at	tor	10a. State 10b. County	,	Town or Loc						10d. Inside City Limits
	Mary 28a-f notifie	Jirec	MD 10e. Street and Number	Ва	1timor	10f. Zip 0	N			10g. Citizen of What C	1X Yes 2 □ No
	vith the 23a ol st be	eral [3111 Juneau Place				214			USA	country?
2:45 a.m. 1215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eted by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 5 Never Married 1 Never Married 7 Never Married 1 Never Married 7 Never Married 1 Never Married 7 Never Married 1 Never Married 8 Never Married 1 Never Married 9 Never Married 9 Never Married 1 Never Married 9 Never	2 No	l II	Yes, specif	Cuban,	Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black, Wh	hite
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2011 rland	d be filed v Aental Hyg Irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) J. Max Zimmer	·			1	8. Mother'	s Name (First, Middle,	Maiden Surname) U	nk
9,	shoulk and N is ma		19a. Informant's Name/Relationship (Type, Print)							er, City or Town, State, 2	· · · · · · · · · · · · · · · · · · ·
ARY e, N	and 2 Health tem 21		Mary Hetherington - n: 20a. Method of Disposition		1617 ace of Dispo			Ka; E	Date Date	Maryland 2	
FEBRUARY altimore, I	Page 1 nent of int: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 🖾 Donation 5 ☐ Other (Specify)	State ce	metery, cren	,					
FEBRUARY 9, Baltimore, Mary	permit. Departn Importa any inju		21. Sign für füngral ice Licensee	irector	22	Name and	Address (of Facility	State Ana ore St; Ba	tomy Board 1timore, MI	21201
	Medical Examiner	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events	caused the death ach line. IENT'TA (or as a conseque) (or as a conseque) (or as a conseque)	ence of):	er the mode	of dying, s	such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
VILLIAM ZIMMER P.O. Box 68760	certific nding p	Physician/Medical	in the past 12 months?	tcome of pregnan Birth 2 Fetal Inant at time of de nown	death 3	Ectopic pr	egnancy			23d. Date of c Month	delivery Day Year
WILLIAM 5, P.O. Box	requires that the death been signed by the atte should be detached for	[출	Part II. Other significant conditions contributing to d	leath but not resu	Ilting in the u	nderlying ca	use given	n in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Uivision of Vital Records,	ne law requii e has been age 2 should	Completed							24a. Was auto perfo	psy prior to ormed? death?	autopsy findings available ocompletion of cause of
<u>a</u>	ian; The	Be C	25. Was case referred to medical examiner?				26. Place Other:	e of Death	(Check only one)	ZAJNO I L	es 2 🗆 NO
of Vil	ing Physic frer this couneral dire	은	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ecify) HOSPICE							
ivisior	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Certificate;	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildi	Rural Route Number,							
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	o the Pithin 24 or the Formplet	Me	only one) 3 X Certifying Nurse Practioner: 29b. Signature and ditle of certifier			leath occurre		ime, date a			as stated.
	FSFÖ		1 ASIMES CAN	P		I	149-	192	_	2/9/2011	
			30. Name and address of person who completed cause	se of death (Item	23a) (Type, P	rint)				+ -//	
	Ct-	10-	21 Date filed Brown May May 1	O DULAN Registrar's Sianatu	.vo /		D. [TIMON	IUM, MD 21	1093	
	Sta Registr		FEB 14 2011 Servey	legistrar's Synatt	gar						

2:45 a.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Year Month Dav Physician/ 0:41.am Medical 4c. County of Death 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death Examiner Takoma Park Montgomery <u>Washington Adventist Hospital</u> 9. Birthplace (State or Foreign 8. Date of Birth Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Country)
Maryland 1 🛛 M 2 🗆 F (Month, Day, Year) 08/28/1942 Director 215-80-4941 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No **Hyattsville** MD Prince Georges 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20785 USA 2003 Woodreeve Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏝 No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meagnes." Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 2nd Street, NW Washington, DC Karim J. Evans - Custodian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 1/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Signature of Funeral Service Licensee Mondgomen 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading is immediated cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consuluence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Dav Pregnant at time of death 5 Other (specify) 2 No signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate | 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of catifier 29d. Date signed (Month, Day, Year) 29c. License number

CR 1

State Registrar son who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Donna Mae Akers January 11:15p^M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) Day, Yea t. 23 **Funeral** Country)
Wisconsin 1 🗆 M 2 🏝 F Hours 399-28-6912 78 August Director Usual Residence of Decedent 10d Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at Director MD Montgomery Potomac 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō Funeral items 23a 20854 9710 Falls Rd. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 K No Specify: SpecWhite If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. University of Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Beatrice Bowen Walter Robert Hatch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Douglas Leo Patin/Son 1703 N. Highland St. Arlington, VA 22201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 2/1/11 Chantilly, VA 4 Donation 5 Other (Specify) Cremation Center 21. Signature of Funeral Syrvice Licenses 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arl., VA 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 2 🗓 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number R 143201 RN me and address of person who completed cause of death (Item 23a) (Type, Print) MUNCOSTER MILLERD BRAK 0

State

Registrar

31 Date filed (Month, Day, Year

2011

FEB 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 16/2011 1748 РМ William Henry Beard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Hospital Montgomery Suburban Hospital 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1X M 2 | F Hours Country) **Director** 579-38-0753 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ı "natural", or items 23a o edical Examiner must be with 1 Funeral IJ S A 20016 4517 Windom Place NW Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: Completed 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HUD Civil Service Federal Accountant Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 William Henry Beard Sr Laura Hooff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Beard / Wife 4517 Windom Pl NW Washington DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Edge Hill Cemetery 1/26/2011 Charles Town, WV 22. Name and Address of Facility Joseph Gawler's Sons Signature of Funeral Service Licent Wille 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, Examine Due to for an a numerousings off If any leading to immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown ped a | Unknown Odetac signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 X No page 2 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 XNo ၉ 1 Inpatient 2 K ER/Outpatient 3 DOA 1 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred After injury 1 XNatural 5 Pending work? death. 2 | No Accident
Suicide Investigation after death Director: / the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in by 4 Homicide determined City or Town, State) illed 24 hours edical

Registrar

State

29a. Certifier

(Check

only one)

3 🗌

29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

JAN

31

To the within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Amit Rajvanshi MD 121 Congressional Lane #409 Rockville, MD 20852

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Jan. 18, 2011

29c. License number

D37891

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#29dperMD, 2/1/11; EMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:10AM Bela Ö 2011 Banyasz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 26, Social Security Number . Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral Min. 1 **₹ X**M 2 □ F Hours Country) Hungary 1928 82 **Director** 086-34-8508 Usual Residence of Decedent Show 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ื No Kensington 28a-f MD Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò Funeral 23a 20895 USA 3705 Emily Street items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Black, White, etc Armed Forces ò 1 Never Married 2 Married 2 No Completed by ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Telecommunications permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumast. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Satellite Communications Satellite Engineer Be . Father's Name *(First, Middle, Last)* Bela Andrew Banyasz 18. Mother's Name (First, Middle Maiden Surname) 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Emily Street, Kensington, MD 20895 19a. Informant's Name/Relationship (Type, Print) Pauline Wright Banyasz/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Jan. 28, 1 Burial 2x Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Alexandria, VA Signatur of Funeral Service Liepnse Francing Address Cormins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final meunot Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury and -transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 4 Pregnant the. 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. I Hospital or Attending Physician: The law requires that the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I ð Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 43 certificate has b lirector, page 2 s autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 010 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ြု 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending e Hospital con 24 hours after death. the Funeral Director: After the funeral Director: After the form of the form Certificat 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ι determined + cal N 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ithin 2 the F To the only one 29d. Date signed (Month, Day, Year) 2011 29b. Signature and title of certific D71462

Registrar

State

31. Date filed (Month, Day,

JAN

Banyasz

60

32. Registrar's Signature

Old Georgetown Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jametury 20ky, 20 Yekr Blumberg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home of Greater Washington Rockville 8. Date of Birth
(Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 92 yrs If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Min. 125-09-0473 Months Days Hours New York Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Montgomery Silver Spring 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 3310 North Leisure World Blvd #82420906 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc δ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Office Manager injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Gerber William Becker permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 North Leisure World Blvd #824 Silver Springomb Sharon Louis - daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place).
King David Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 🔏 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 1/24/2011 Falls Church, VA Signature of Funeral Service Licensee 22. Name and Address of Facility M01163any Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner NTIFIED ORGANISMS DE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events the attending physician and hed for use as the bunal-tra-Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the all d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page performeda 1 Yes 2 No Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: funeral director, **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 28d. Describe how injury occurred After To the Hospital or con-within 24 hours after death.

To the Funeral Director: Aft
Completed filled in by the fur 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 28

LYMPERG

bizi MONTRESE RD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

149

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State Registrar		Otate of	i wayan		rtificate of L		TVIOITE I	Reg. No.	2011	The second
Physicia Medic		1. Decedent's Nam Dewey		Last) McKinley		Bre	eden		2. Date of I	Day	30, 201	3. Time of Death
Examin		4a. Facility Name (if		give street and numi	ber)		4b. City, Town, or Hagerst		ath		County of Deat	
Funeral Director		5. Social Security N 219-12-2	lumber (7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Birth Dav. Year)	9. Birt	hplace (State or Foreign untry) ginia
nd how at	٦	Usual Residence of 10a. State			10c. City	, Town or La	cation					10d. Inside City Limits
Maryla 28a-f s otified	Funeral Director	MD	<u> </u>	ngton	Ная	gersto						1 🎇 Yes 2 □ No
/ith the 23a or st be n	ral D	10e. Street and Nur 415 Chur					10f. Zip Code 21740	2		10g. Citiz	en of What Co	untry?
death v		11. Marital Status	ten be.	12. Was Deced	dent Ever in U.S	13.	Was Decedent of H	ispanic Origin? (Specify Yes or N	0- 1-	4. Race - Ame Black, White	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na					ng Address (Street Church St				Fown, State, Zij	o Code)
of Hea of Hea if item or other		20a. Method of Dis	position	3 ☐ Removal from	State C	lace of Dispo emetery, crea	osition (Name of matory or other plac	ce)	Date	_	cation - City or	Town, State
it. Page intment intant: I injury o		4 Donation	5 Other (Sp	pecify)	Smi		rg Cremat 2. Name and Addre				thsburg	
permii Depar Impor any ir once.		21. Signature of Fu	Auck .	Suins			601 Penns					-
Physician/		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition	art failure. List or (Final	complicators that conly one cause on each	ch line.		er the mode of dyin			/	_	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	-	Due to (or as a consedu	ience of):	1 10 9					
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To the Hospital or Attanding Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12	months?		come of pregna Birth 2 Feta nant at time of c	Ideath 3	Ectopic pregnan	су		2	23d. Date of de	livery Day Year
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Physic r this ce ral dire	은	1 Yes 2	No th	28a. Date	Inpatient 2.X	ER/Outpatie 28b. Time o		4 ☐ Nursing	Home 5 Re	esidence 6		cify)
eath. or: Afte the fune	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investig	ation	h, Day, Year)	injury	M 1	k̂? Yes 2 ☐ No				
al or Att s after d il Direct		4 Homicide	determin	ned 28e. Place	of Injury - At ho ng, etc. <i>(Specif</i> y		reet, factory, office			n (Street and Town, State)	Number or Ru	ıral Route Number,
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2	2 Medical Ex	Physician: To the be kaminer: On the bas Nurse Practioner:	is of examination	and/or inves	stigation, in my opini	on, death occurre	ed at the time, dat	e and place,	and due to the	cause(s) and manner stated
To the vithin To the compl	Σ	29b. Signature and		0 0 0	to the pear of m	y Niowiedge,	29c. Licens		piace, and due to		e signed (Mont	
iF.		30. Name/and add	ress of person w	who completed caus	e of death (Item	23a) (Type	Print)	10035)	14/1/	2011	21740
1-15		Cyn	Thia?	S. Shu	mp	CRI	VP 11	01 04	Pal Cou	et H	weistr	un med
Stat Registra		31. Date filed (Mon	FEB 1 2	2011	egistra/s Signa	ture.	have					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 14:20 PM Conrad Eugene BAKER 2611 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 952 Chestnut Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Min. 1929 81 Maryland Director Feb. 220-26-0117 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Washington Hagerstown 1 X Yes 2 ☐ No ե 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21740 952 Chestnut Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Marital Status rmed Forces?

No 1948 Black, White, etc. ò ģ 1 X Never Married 2 Married within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 1952 Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) Truck Co. machine operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Harry Samuel Baker Edna R. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Madison Lane, Cataula, George Mark Baker - son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State February Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2011 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Examiner HYPERTENSION Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERLIPIDEMIA 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 2 🗌 No 1 Yes Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) D58810 MNUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204 12916 Conamar HAgerstown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

FEB 0 1 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BATRA NIRMALA B 201 7:25A JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Days Hours Year 1941 1 🗆 M 2 🔀 F March 5 69 Pakistan Director 214-37-3478 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am pring or other traumatic event, the Medical Examiner must be nortified once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Carrol1 Mount Airy Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21771 6640 Wind Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Asian Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Government of India Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lilawati Nirmala Bawa Charan Bedi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6640 Wind Ridge Rd., Mt. Airy, MD 21771 Kamal J. Singh / Son Date 24, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2011 Frederick, Maryland Resthaven Crematory 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility} Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. 21. Signature eral Service cense Skkot Cody Frederick, P.A MĎ 21701 23a. Part 1. Enter the disease shock, or leart failure. Li complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ेग्ysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Examine Que to for as a nonsequence off: Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day 5 Other (specify) Month Year signed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No |은 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

Registrar

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 8:30p January Clara B. Berlinsky Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Mt. Airy Carroll Mt. Airy 8. Date of Birth (Month, Day, Year) May 29, 1917 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Months Hours Min. New York May 578-09-6376 Director 93 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 K No Maryland Woodbine Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be Funeral 3211 Florence Road 21797 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🛛 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Nidowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Valentini John Greco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan B. Murray/ Daughter Florence Road, Woodbine, Maryland 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery1/28/2011 4 ☐ Donation 5 ☑ Other (Specify) Entombment Silver Spring, Maryland Name and Address of Facility tauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Signature of Fund Service Liouse 23a. Part 1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examine rr any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ģ Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 s been signed by the sign should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Physician: The law requires Records, 1 Tes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy perform death? 2 🗆 <u>No</u> 1 Tyes Yes 2 Assisted of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Paci ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending Division 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

28

gistrar's Signature

MARKAN.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

4701 Randolph Rd #216, Peckville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Physician/ 23 2011 \mathbf{p}^{M} <u> Henrietta A. Barnes-Hill</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Manor Care <u>Chevy Chase</u> 8. Date of Birth (Month, Day, Year) 01/14/1909 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday 1 Year If Under 24 Hrs. **Funeral** Days Min. Hours 1 □ M 2 🖾 F Months Director 578-26-3524 102 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Chevy Chase MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20815 8700 Jones Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Specialist Data Entry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Annette Jones Abraham Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20018 Elmer H. Brown - Son Franklin Street, NEinjury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 02/01/2011 | Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Bladensburg Road Brentwood, MD 20722 Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) inos Norws Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Other (specify) signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital 2 No 1 Tyes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25/11 00054566

State Registrar

DHMH 17 Rev 7/2009

980160

32. Registrar's Signature

Annua #117

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bho gaville

writha

31. Date filed (Month, Day, Year)

FEB 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan 31 Maryann Biggins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Brighton Gardens Columbia Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. 1 M 2 X F 1171171924 Director 86 Yrs. 067 18 7530 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7505 B Weatherworn Way 21046 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Security Receptionist Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Rexin Joseph Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7505 B Weatherworn Way Columbia MD 21046 Patricia Hilton/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Ardent Crematory 2-1-2011 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Collins 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Exacerbation of Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 🔀 No Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ pneumonia Records, Completed peripheral vascular disease 24a. Was an page 2 s autopsy performed' certificate Yes 2X N of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 🔀 Natural 5 Pending work Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af Accident Suicide 1 Yes 2 No the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other: $_{4}$ \square Nursing Home $_{5}$ \square Residence $_{6}$ \boxtimes Other (Specify) Asstd. 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29c. License number 29d. Date signed (Month, Day, Year) 2-1-2011 D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Parkway #301 Columbia, MD 21045

3. Time of Death

9. Birthplace (State or Foreign Country)

NTV

NY

White

10d. Inside City Limits

MD 21043

Approximate Interval Between Onset and Death 10 yrs.

1 Yes 2 X No

3:02 P M

20ÎÎ

Registrar

State

29b, Signature and title of certifier

Day Year

FEB

Harry Li

31. Date filed (Month.

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physician/ Medical Examiner **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

1 - For Amend Items 25 per dr Registrar	aryland , Bep Cei	artment of Heart rtificate of Dea	alth and M ath	lental Hygien Reg. N	e 0 1 1	04108		
Decedent's Name (First, Middle, Last) ANNIE CLEO BERGLING				2 Date of Death	av Year	3. Time of Death 7:56 P M		
4a. Facility Name (if not institution, give street and number) 8245 MARY LEE LANE	ET .	4b. City, Town, or Loc LAURE	cation of Death	4	 County of Dea 	GEORGES		
577-32-9966 1 DM 2 DX	e (In yrs. last birthday) 83 Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth 12/15/192	7 TE	irthplace (State or Foreign NNESSEE		
Usual Residence of Decedent	10c. City, Town or Lo H E	cation EDGESVILLE				10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
10e. Street and Number 210 CONSERVATIVE LANE	Citizen of What C	Country?						
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Wo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Arr Black, Wh 1 Yes, Sive 1 Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - Arr Black, Wh 17. Specify:								
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give	dent's Usual Dccupatio kind of work done durir O NOT use retired) FREX MANAGE	ng most of workir	16b.	Kind of Busines	s Industry HINGTON POST		
17. Father's Name (First, Middle, Last) ROBERT LOUIS ROGERS		18	. Mother's Name	(First, Middle, Maide NNIE LAUR <i>A</i>	n Surname) LAM			
19a. Informant's Name/Relationship (Type, Print) LUCY BERGLING/DAUGHTER	19b. Mailii 8245	ng Address (Street and 5 MARY LEE	Number or Rural LANE, L	Route Number, City AUREL, MD	or Town, State, Z 20723	Zip Code)		
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cred ROSEDALE C	osition (Name of matory or other place) EMETERY	JAN. 1 201	.8,	Location - City o	or Town, State NSBURG, WV		
21. Signature of Funeral Service Licensee	22	2. Name and Address o 327 W. KING		WN FUNERAL H INSBURG, WV	10ME, PO E 25402	30X 821,		
23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)			uch as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death MONTHS		
Sequentially list conditions.	a consequence of):							
cause. Enter Underlying Cause (Disease or iinjury that initiated events C	a consequence of):	_						
d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year		
Part II. Other significant conditions contributing to death by MYELODYSPLASTIC SYM		underlying cause given	in Part I.			to the cause of death? Probably 4 🗡 Unknown		
				24a. Was an autopsy performed?	prior to death?	uttopsy findings available completion of cause of		
25. Was case referred to medical		26. Place	of Death (Check	only one)	No 1 L Ye	es 2 🗆 No		
examiner? 1 ☐ Yes 2 🌠 No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatier	nt 3 DOA Other:	4 Nursing Hor	me 5 kg ne sidence	6 X Other (Spe			
27. Manner of Death 1 X Natural 5 Pending (Month, Da) 2 Accident Investigation	ry 28b. Time of injury	work?	2 🗆 No	28d. Describe how inju	ury occurred	Residence		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e, Place of Injuiding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Street a City or Town, Sta		ural Route Number,		
29a. Certifier (Check conly one) 3 Certifying Physician: To the best of 2 Medical Examiner: On the basis of each conly one) 3 Certifying Nurse Practioner. To the	xamination and/or inves	stigation, in my opinion, o death occurred at the tin	leath occurred at ne, date and place	the time, date and place, and due to the cause	ce, and due to the e(s) and manner a	e cause(s) and manner stated. is stated.		
29b. Signature and title of certifier))~	29c. License nu	1395	JA	ate signed (Mon	15,2011		
30. Name and address of person who completed cause of control of the control of t	eath (Item 23a) (Type, F 701 N CHA	Print) RLES ST, SU	1124105	BALTIMO	RE, MD	21204		
30. Name and address of person who completed cause of cause of completed cause of completed cause of ca	ar's Signature	Kel						

DHMH 17 Rev 7/2009

15

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State State Registrar	of Maryland / I	Departmer <i>Certificat</i>				ene g. No.	04/09
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	Examin	er	4a. Facility Name (if not institution, give street and nu		4b. City		ocation of Death endal	3	4c. County of Dea	ıth
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs, last birt	Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Bin	rthplace (State or Foreign
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	/land f show ed at	tor	10a. State 10b. County	10c. City, Town	n or Location					10d. Inside City Limits
	e Mary r 28a- notifie	Direc	MD. PRINCE GEORGE':	3	SUIT	LAND c Code				1X Yes 2 No
	with th	Funeral Director			10f. Zi		746	10	ng. Citizen of What C	ountry?
	leath v	Fune	3414 CURTIS DR. 11. Marital Status 12. Was Dec	edent Ever in U.S.	13. Was Dece	dent of Hist	panic Orlgin? (Spe Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
326	should be filed within 72 hours after death with the Maryland and Memtal Hygiene. and Memtal Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, G 3 ☒ Widowed 4 ☐ Divorced Year or I	orces? 2X No ve		2X No		riidari, etc./	Black, Whit	LACK
Maryland 21215-0036	hours hatur dical l	Completed	15. Decedent's Education (Specify only highest grade completed	16a	. Decedent's Usu		on ring most of work	ing 1	6b. Kind of Business	
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/an	d be fi Mental arked aric ev	٥	JOHN H. JACI	KSON			А	DLA	DOWE	
Jan.			19a. Informant's Name/Relationship (Type, Print)						City or Town, State, Z	
a)	and 2		ISABELLA EVANS/DAUGH' 20a. Method of Disposition		57 S. I				ROSS, VA. Oc. Location - City o	
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Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Ocensee	(i)	22 Name a CHAMB	d Address ERS FI	ONERAL H	OME & CR	EMATORIUM	,P.A.
			23a. Part 1. Enter the disease, or complications that	M00091	<u> 5801</u>	CLEVE	LAND AVE	., RIVER	DALE, MD.	20737 Approximate
	flysician,		shock, or heart failure. List only one cause on e Immediate Cause (Final	ach line.	ast				• 9	Interval Between Onset and Death
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POX	With 124 hours that darkending Physician: The law requires that the death certificate be executed within 24 hours fard eath. To the Funeral Director After this certificate has been signed by the attending physician any completed filled in by the funeral director, page 2 should be detached for use as the burial-to-	Physician/M		gnant at time of death	5 Other (s				Month	Day Year
7. O	that the ned by detac	by Ph	Part II. Other significant conditions contributing to	death but not resulting i	in the underlying	cause giver	n in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
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Records,	law re has be e 2 sho	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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0	ing Ph ifter thi ineral		27. Manner of Death 28a. Date	of injury 28b. 1		28c. Injury a work?	ıt /	28d. Describe how		
VISION	death death ctor A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At home, fa	M street factor		es 2 🗆 No	28f Location (Stre	et and Number or Ru	ural Route Number
Š	salor As fter salor As fter all bire	II Cer	4 Homicide determined build	City or Town,		and reduce realised,				
	Hospit	edical	29a, Certifier (Check Medical Examiner: On the ba	sis of examination and/o	or investigation, in	my opinion,	death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
	within To the	Σ	only one) 3 "Certifying Nurse Practioner 29b. Signature and title of certifier		100	Licancan	umbar	1 00	d Date signed (Moss	th Day Vond
			> XIMMAD			DO	06420	8	1-27	-2011
			30 Name and address of person who completed cau	se of death (Item 23a) ((Type, Print)	1,100	+ Her	4 Rim	erdalo	- 2011 MD 20737
۲	Stat		0.00	Registrar's Signature	Land	9	1,00	0		. 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ohill Year 2015 3.05 PM JAN 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Palticent Health and Rehab Loursel Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, 9. Birthplace (State or Foreign Year) 1 🛛 M 2 🗆 F Months Days Hours Min. Washington, DC 578-60-3547 Director 65 6/29/1945 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Prince George's Director 1 □Yes XX No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14200 Laurel Park Drive 20702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Navy 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: \$ Specify: Specify: 3 ☐ Widowed 4 🗓 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm M. Elementary/Secondary (0-12) College (1-4or 5+) 12 Correctional Officer Law Enforcement 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ John A. Cohill Ethel Noel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Taylor - Daughter 5601 Willoughby Newton Dr. #15, Centreville, VA 20120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 1/23/2011 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility National Funeral Home CC 05117 7482 Lee Highway, Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Followe 10 Thrive months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic 2013 8/5 months Sequentially list conditions, if any, leading limited and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed ending physician and use as the burial-tr nsi Due to (or as a consequence of): Box 68760, Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) o. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by t σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Inbrillation 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been colon comer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate of Vital 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4. Nursing Home 5 Residence Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation J Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide completely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Jan 21th 53411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jogalish /shesadni

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State Registrar Gallant

31. Date filed (Month, Day, Year)

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22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Helen Regina Coates 27 2011 2:35 Jan, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Encore at Turf Valley Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1 □ M 2 👽 F Director 263-28-8846 86 26, Jan. 1925 Chio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show official Exercitives of the notified at Director 1 ☐ Yes 2 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with 11150 Resort Road, Suite 116 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed withi Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) Nurse Practitioner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur John Duffey Theresa Catherine Conlon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i 2494 Amber Orchard Ct., Odentor, MD 21113
of Disposition (Name of Date 20c. Location - City or Town, State <u>Cecile M. Ledford/Daughter</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Feb. 2 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final U/WONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burn transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 6 Other (Spec 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) ania 28, 2011 Columbia Mary 30. Name ar erson who completed cause of death (Illem 23a) (Type, Print) Le don 19 M 34 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ January 24, 2011 Charles William Clark 10:10 p Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care-Bethesda Bethesda Montgonery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1935, 1935 Months Days 1 AM 2 AF Hours **Director** 220-32-5889 D.C. Usual Residence of Decedent Should be filed within 72 nours and the should be seen that and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show the marked other than "natural", or items 23a or 28a-f show are seent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5922 Dorchester Way 20852 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 132 Yes 2 No If Yes, Give Year or Dates. 1954–57 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Plant Engineering Manager Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas M. Clark Ida Marion Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Patsy H. Clark/Wife 5922 Dorchester Way, Rockville, MD 20852 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 28, Jan, Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 2011 Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W,, Silver Spring, MD 20901 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition PARKINSON'S Physician/ DISCASE Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and I-trunsit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐No 24a. Was an autopsy 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director After th completed filler in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Danatural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices: (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) sew, uns 00057124 1127111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bac, MD 10110 Molecular Drive, #206, Rockville, MD 20850

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25^{ay} JAN. 20^{rgar}1 SALLY A. CAW 12:05PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 0^{Month}5^D7^V1^Y9^r3 3 217-30-6850 WASH. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State with the Maryland 10c. City, Town or Location Director MD MONTGOMERY POOLESVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17209 BROWN ROAD 20837 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM KEECH WILSON SALLY ABELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, JOSEPH CAW, JR. / SPOUSE 17209 BROWN RD., POOLESVILLE, MD 20837 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date st. MARY S 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/29/201 BARNESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BOX 86 HILTON FUNERAL HOME BARNESVILLE MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Show septic disease or condition resulting in death) Medical Due to for as a consequence of Examiner edema cerebral Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): acidosis Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as ystole Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: Other: ျ 1 DOA Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide iniury 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Amare Abebe , MD 01/25/11 1005255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Maryland 20850 medical Center Drive, AMARE ABEBE MD 9901 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 26/2011 WILLIAM GILBERT CONTEE 0724 М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE"S SOUTHERN MARYLAND HOSPITAL CLINTON 8. Date of Birth (Month, Day, Year 1/10/1942 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Min Hours 1 TXM 2 T F Director 219-40-0531 69 Vrs Anne Arundel MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No Maryland Prince George's Forestville 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3001 Logan Street 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Examiner Armed Force Black, White, etc. 9 Completed by 1 Never Married 2 X Married 1 Yes Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Black traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha <u>Brick Laver</u> Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Merle Gilbert Contee Agenes Virginia Creek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Christine V. Contee / Wife 3001 other Logan Street Forestville, Maryland 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town. State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify Washington National 2/5/2011 Suitland, Maryland ur of Funeral Service Li 22. Name and Address of Facility Pope Funeral Homes, P.A. MUION 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h performed? Yes 2 XNo 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Gertifying Nurse Practioner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine Street January 27, 2:45 P. Chilman 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Collington Episcopal Life Care Mitchellville Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 20,1914 1 M 2 Set Days Hours Months 109-26-9890 96 Director Usual Residence of Decedent show Page 1 and 2 should the filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tifered 275 in smarked other than "natural", or items 23a or 28a-f show ant. If item 275 in smarked other than "natural", or items 23a or 28a-f show try or other traum wite event, the Medical Examiner must be notified at ury or other traum wite event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified MD Prince Georges Mitchellville 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 10450 Lottsford Road 20721 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Bace - American Indian Armed Forces? 1 ☐ Yes 2 ☑ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Professor Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elwood Vickers Street Augusta Jewitt 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Carpenter/Daughter 58 MeadowBrook Road, Norwell, MA 02061 portant: If item 2, injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott
once. January centetery, crematory or other place)

Medial Center 27 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2011 4 Monation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 SUL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) ENTIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 mont Ectopic pregnancy Month Dav Year Pregnant at time of death other significant conditions contributing to death but not resulting in the underlying cause given in Part (RONIC OBSTRUCTIVE PULMONARY) 23e. Did tobacco use contribute to the cause of death? þ ULMONARY DISANT 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 🗌 No 1 Yes Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) e Hospiu...
in 24 hours after death.
the Funeral Director: After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certiff 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEXFORD 1500 HANOVER, PARKWAY, #101A, GREEN

Registrar

State

	David	Rufus	Callaham
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avid Rufus Ca	llah	1- For State	ate of Maryla		epartment o		d Mental		20				
Physici	an/	Registrar 1. Decedent's Name (First, Middl	e,Last)					2. Date of Dea		3. Time of Death			
ledical Exami		David Rufus	Callah	ı ə m				Month January 2	Day Year 23, 2011	0213 hrs			
		4a. Facility Name (if not institution				4b. City, Town, or	Location of De		4c. County of				
		Prince George's Hosp	ital Center			Cheverly			Prince Ge	eorge's			
Funeral		5. Social Security Number	6. Sex	7. Age (In y	yrs. last birthday)	If Under 1 Year				Birthplace (State or Foreign			
Director		219-23-8582	1 M 2 F		21 Yr	Months Days	Hours N	May 7	7,1989	Country)			
		Usual Residence of Decedent						1224 ,	71000	LWash.,DC			
v any		10a. State 10b. County		10c.	City, Town or Loca	tion				10d. Inside City Limits			
and show	5	MD P	G		Upper M	arlboro				1 XYes 2 No			
Maryland 28a-f show	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	at Country?			
with the Maryland ms 23a or 28a-f sho be notified at once	ä	9602 Mount	Laurel C	ourt		207	772		United	d States			
with the ms 23a be noti	Funeral	11. Marital Status	12. Was Dec			as Decedent of His			- 14. Race -	American Indian, Black,			
death rr iten	'n	1 Never Married 2 Ma	Armed Fo	2 X N		es, specify Cuban,	, Mexican, Pue	rto Rican, etc.)	White,	etc.			
after al", o	by F		orced If Yes, Give Yea	г	1	Yes 2 No	specify:		Specify:	Black			
ours latur		15. Decedent's Education (Spec	cify only highest grad	de complete	d) 16a. Decede	nt's Usual Occupati	on (Give kind o	of work done	work done 16b. Kind of Business/Industry				
6 172 h	ete	Elementary/Secondary (0-12)	College (1	-4 or 5+)				etired)					
5-0036 iled within 77 Hygiene. I other than	Completed		1		1	Musiciar				ırch			
15-00 filed wit Hygien d other		17. Father's Name (First, Middle,	Last)			1	8.Mother's Na	me (First, Middle, I	Maiden Surname)				
ID 21215-00; should be filed within and Mental Hygiene. The marked other that event, the Med	Be	Rufus Calla 19a. Informant's Name/Relationsh			Lie or w		Alici	e McKo	У				
D 21 should and Me	၉				196. Mailin	g Address (Street Thistle	and Number o	r Rural Route Nun Drivc	nber, City or Town,	State, Zip Code)			
FIG. MD 21215-0036 1s. I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shore trammatic event, the Medical Examiner must be notified at once		Rufus Callaha 20a Method of Disposition	am/fathe	r	Ob. Place of Dispo			075	20s Lasation C	City or Town, State			
S 1 a of He tit		1 Burial 2 Cremation	3 Removal fro		crematory or of		ietery,	Date	20c. Location - C	only or Town, State			
Page Page or of		4 Donation 5 Other Sp			Resurre	ction Ce	emeter	y 1/29/	11 Cli	nton,Md.			
Baltimore, MC permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21 Signature of Funeral Service	Lîcensee	A /	22. I	Name and Address	of Facility H	odges &	Edward	ds F.H.			
E.E.G.S.		Januce 1	awarc	ls			ver Hi	11 Rd.,	Suitla	nd, Md. 20746			
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the de	eath. Do not enter t	he mode of dying, s	such as cardiad	or respiratory arr	est, shock, or hear	t Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease	a. Multiple Inju	uries						Death			
	ļ	or condition resulting in death)	Due to (or as a	consequen	ce of):				· · · · · · · ·				
	اءِ	Sequentially list conditions,	b										
	اڃَ	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequen	ce or).								
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):					-			
on of Vital Records, P.O. Box 68760, rading Physician: The law requires that the death certificate be executed ath. The After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi			d										
oe exe	dical	UNPENDED	AMENDED										
OX 68760, eath certificate b attending physic for use as the but	\$	IF FEMALE:	23c. If yes, o	outcome of p	pregnancy				23d. Date of de	elivery			
68 certifi ding	ā	23b. Was decedent pregnant in the past 12 months?	I LIVE D	rth ant at time o	5 de eth	tal death 3	Ectopic preg	nancy	Month	Day Year			
Box of death of the attended for us	Sic	1 Yes 2 No 9 Unki	nown 9 Unkno		or death 5 O	her (Specify)							
D. B t the d by the	Physician/Me	Part II. Other significant condition			not resulting in the I	inderlying cause giv	ven in Part I	23e. Did to	bacco use contribu	ute to the cause of death?			
ires that to signed by the detact	Ď		_		g					Probably 4 Unknown			
rds, require peen signaled b	ted							24a. Was a		ere autopsy findings available			
aw re	흺						-	autop	sy prid	or to completion of cause of ath?			
Zec The l	Completed							1 Yes		Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requints after death. al Director: After this certificate has been sted in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner?				1.0	of Death (Chec	k only one)					
bysic al dire	2	1 ✓ Yes 2 No			✓ ER/Outpatient			• -	Residence 6				
After		27. Manner of Death 1 Natural 5 Dead	28a. Date of (Month)	of Injury Day,Year)	28b. Time of I		at Work?		now injury occurred struck by auto				
ior ttend leath.	iğ	Pendi	ng Jan 25, 2 tigation	2011	0010 hrs	1 Ye	es 2 🗸 No	, odosinan e	indon by date				
or Atte or Atte after dea Director	흹	3 Suicide 6 Could	not be 28e. Place	of Injury - A	At home, farm, stree	et, factory, office bu	ilding, etc.	28f. Location (S or Town, S		or Rural Route Number, City			
ours ours filled	Certification:	4 Homicide determ	mined (Specify)	Major R	oad / Highway			I-495 North of	Route 202, Land	dover, MD			
Division To the Hospital or Atter within 24 hours after deal To the Funeral Director completely filled in by th			ysician: To the best										
To th within To th	Medical	- 32	niner: On the basis o and manner st		on and/or investiga			at the time, date a					
1	Σ	29b. Signature and title of certifier				29c. License			29d, Date signed	(Month, Day, Year)			
4		mes_				O.C.M	1.E.		January 23, 2	2011			
77	t	30. Name and address of person v	· ·										
CAR.		Ana Rubio MD. Assi	stant Medical E	xaminer	900 W. Balt	more Street, B	Baltimore, N	ID 21223					
Sta	~~	31. Date filed (Month, Day, Year)	32. Res										

ORIGINAL

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

or		84-22-)	85	Yrs.				Jan. 23,	1928 Ma	ryland			
		sual Residence o la. State	f Decedent 10b. County		10c. Ci	ity, Town or L	ocation					10d. Inside City Limits			
5	L					Crist	1 1					1 □ Yes 2 No			
ect		Caryland De. Street and Nu	Some	rsei	1,8	CVID	10f. Zip Code			10a. Ci	tizen of What C	ountry?			
Funeral Director	'`	4794	Crist	eld.	HWY			817		1 3 3	U, S.	*			
nera	1	I. Marital Status	- • • •	12. Was D	ecedent Ever in U	J.S. 13.	Was Decedent of If Yes, specify Cu	· /	in? (Specify	Yes or No-	14. Race - Am	erican Indian,			
		1 Never Mar	ried 2 Marri	ed 1 1 1 Ye	Forces? es 2 ☐ No Give 1953 ~ r Dates:		1 ☐ Yes 2 ☑ No		Puerto Rica	an, etc.)		Black, White, etc.			
d by		3 Widowed	4 Divorced	Year o	r Dates: 453	1935	To res Zignino	эрвону.			Specify: 8	lack			
Completed	1	(Spec	15. Decedent cify only highes	's Education It grade complete	ed)	(Give	edent's Usual Occi e kind of work don	during most of	of working	16b. k	16b. Kind of Business/Industry				
E P		Elementary/Seco		College	e (1-4or 5+)	ine.	Laborer	· /		Ta	cce 1	1-0 To 0			
									's Name <i>(Fi</i>	Jesse Long Inc.					
To Be					Cv 11.	en		0	llie	Whitt.	in tan				
F	1	9a. Informant's N					ing Address (Stree			oute Number, City		Zip Code)			
		Mari	Culle	n - wi	fe	4	794 (visfie	id +	tour co	Stop 12	md, 71817 r Town, State			
	20	a. Method of Dis	position		20b.	Place of Disp									
			☐Cremation 5☐Other (Sp	3 □Removal fro pecify)	om State	اامسم	u.m.c. Cer	retery 3	2151	11 H	pewell	ind.			
	2	1. Signature of	neral Service I	icensee	1	2	22. Name and Add	ess of Facility	Am	thony E.	Ward	F. H.			
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Part 1. Enter the disease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,														
												Approximate Interval Between			
	d	Isease or condition	n			1	1T					Onset and Death			
	n	esulting in death)		Due	to (or as a conse	quence of):	_								
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Examiner	if	equentially list co any, leading to in ause. Enter Under	nmediate erlying	Due	to (or as a conse	quence of):									
xam	th	ause (Disease or nat initiated events esulting in death)	S	C. Due	to (or as a conse	unence of).									
al E				a buc	10 (01 43 4 001130	quenoc oi).									
dic				d											
Physician/Medical		FEMALE:	t prognant	23c. If yes,	outcome pf pregr	nancy					23d. Date of d	eliverv			
ciar	2	23b. Was decedent pregnant in the past 12 months? 1 □ Vec 2 □ No. 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									Month	Day Year			
ysi															
by Pi									23e. Did tobacco	obacco use contribute to the cause of death?					
g p								1 ☐ Yes 2	Yes 2 No 3 Probably 4 U						
leted										24a. Was an		autopsy findings available			
Compl	-							-	_	autopsy performed? 1∐ Yes 2⊠ N	death?				
a)	2	5. Was case refe	rred to medical					26. Place of	of Death (C	1□ Yes 2X N Check only one)	0 1016	35 Z [NO			
O.B		examiner? 1 Yes 2 □	No	Hospital: 1	□ Inpatient 2	ER/Outpatie	ent 3 DOA	ther:		5 Residence	6 □Other (Sp	ecify)			
n:T	2	7. Manner of Dea		/4.	ate of Injury fonth, Day Year)	28b. Time Injury				. Describe how inju		**			
atio		1 Accident	5 Pending investig	ation	roman Day Today	,,		∃Yes 2□N	10						
ertification		3 ☐ Suicide 4 ☐ Homicide	6 □ Could n determi	ned 200. Fit	ace of injury - At I ilding, etc. (Spec		treet, factory, offic	9	28f.	Location (Street a City or Town, Sta		Rural Route Number,			
Cer	L														
edical	2	9a. Certifier (Check only								I due to the cause(at the time, date a					
Medi	-	one)			nanner stated.										
~	2	9b. Signature and	utile of certifier	10	10	3		nse number	7	29a. D	ate signed (Mo				
			(A					48098				-011			
	3	0. Name and add	ress of person	who completed c	ause of death (Ite	m 23a) (Type	201 1-1	all 1-	ticle	way. C	ri fret	dmn 2181;			
ate	3	1. Date filed (Mor	oth Day Year)	,	2. Registrar's Sign)		7	1			
4 1 2 3			,, 1041/	02											

State

Registrar

FEB 01 2011

1-00798		Please Type or F									ible.	011	OI.	119
ames Crane		State of	Maryland .			it of Heal e <i>of Deat</i>		d Menta	Нуді	ene	6	_ U I I	UH	110
Dharisi	/	Registrar 1. Decedent's Name (First, Middle,Last)		Cert	meate	e or Deal			2 1	Reg Date of Death	3. No.		3. Time of De	eath
Physicia Nedical Exami		James	Cr	ane					1		Day	Year	1339 hrs	
No. of the last of		4a. Facility Name (if not institution, give str Howard County General Hosp	eet and number)			4b. City,		Location of D			4c. C	ounty of Death	1	
Funeral Director		5. Social Security Number 6. Sex 216 98 8688 1 1 ☑ M		e (In yrs. Ia: 45	st birthda	y) If Und Month	ler 1 Year		Min.	Date of Birth	•	Foreig	thplace (State on the control of the	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	own or L	ocation							10d, Inside C	ity Limits
Maryland 28a-f show	힏	Maryland Howard			Je	essup								2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e. Street and Number 8450 Dorsey Run Road				10f. Zip		20794		109	Uni	n of What Coul ted Stat	es	
15-0036 filed within 72 hours after death with the Maryland Hygiene. so other than "natural", or items 23a or 28a-f sh i, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married	. Was Decedent Armed Forces? Yes 2		. 13		ify Cuban	, Mexican, Pu			14	White, etc.	can Indian, Bla	ack,
s after ral",	Ą		Dates:	alatad\ I	160 Doo			specify:	l of work	dono I		d of Business/	lack	
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9030 vithin ene.	E	7th				Disabled						/A		
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112 Id be Aenta	To Be	James H. Crane, Sr. 19a. Informant's Name/Relationship (Type,	Print)		19b. M	lailing Address	S (Stree			hnson Route Numb	Zip Code)			
imore, MD 21 Pages I and 2 should I ment of Health and Met tant: If item 27 is ma or other tranmatic ev	Ě	Rosa Crane (Mother)	,			6 Glenel						or rown, otato	, בוף סטטטי	
ore, N es 1 and 2 of Health If item 3		20a. Method of Disposition			ace of D	isposition (Nar	me of cer		Da			cation - City or	Town, State	
ages l		1 X Burial 2 Cremation 3 F	Removal from Sta			or other place) emetery)	Fz	sh 5	2011	Corr	dele, Ga		
Baltimore, permit. Pages la Department of He Important: If its injury or other ti		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen	100	153			l Address	of Facility Le	e Fu	neral Ho	me.Ji	nc 6633 (Old Alexa	andria
in in Dept.		thumam 2			´	Ferry Ro	ad, C	linton,	MD 2	20735	, , ,			201 10
Physician		23a. Part I. Enter the disease, or complicati failure. List only one cause on each li		the death, i	Do not er	nter the mode	of dying,	such as cardi	ac or res	piratory arres	t, shock	, or heart	Approximate Between Or	
/Medical Examiner		Immediate Cause (Final disease a. C	ardian										Deat	th
			to (or as a conse yperten			iovaccı	ılar	Diceas	20					
	er	If any leading to immediate Due	to (or as a conse			1014000	JIGI	DIOCUL	<i>,</i> –			_	,	
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e executed sian and rial - transi	Jical	X UNPENDED AN	MENDED 23a	-b. nt	. TT . 1	27.0915	5 5-1	17–11 s	sm					
760, cate b	Me	IF FEMALE: 23	3c. If yes, outcom	ne of pregna	ancy	21,671.	-				23d. [Date of delivery		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Live birth Pregnant at Unknown	time of dea	2 L th 5 L	Fetal death Other (Spe	_	Ectopic pre	egnancy		Mo	onth [Day Y	/ear
O. B. at the de de tached f		Part II. Other significant conditions con	tributing to death	but not res	ulting in	the underlying	cause g	iven in Part I.		23e. Did tob	acco use	e contribute to	the cause of de	eath?
s, P.O.	d b	Schizoaffective Disord	ler/Schizo	phreni	a Und	<u>iffrenti</u>	ated	Type.	_			lo 3 Prob	ably 4 Ur	nknown
ords w requisional	Completed	<u>Diabetes mellitus</u>							_	24a. Was ar autopsy	/ !	prior to c	topsy findings a completion of ca	
Reco The law cate has	E O									perform 1 ✓ Yes 2		death? 1 ✔ Ye	s 2	No
tal Rec	Bec	25. Was case referred to medical examiner?						of Death (Ch	eck only	one)				
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n of ding P	ë.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Dey,Y	ry ear)	285, JIM6	e of Injury		yatWork? ′es 2 ∏ No	280	. Describe ho	w injury	occurred		
SiOr Attender r death ector: by the	cati	2 Accident Investigation	28e. Place of In	iury - At bon	ne form	street factory			28f	Location (St	eet and	Number or Ru	ral Route Numi	her City
Divising pital or At ours after deral Direct filled in by	Certification	3 Suicide 6 Could not be determined	(Specify)	diy - Attion	io, iaiiii,	Street, factory	, onice p	unung, etc.	201.	or Town, Sta		Number of Nu	rai Noute Huin	ber, only
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On	the basis of exar											
Son With	Me	29b. Signature and title of certifier	manner stated.			290	c. License	number			29d. Dat	te signed (Moi	oth, Day, Year)	
		D-m) -	-				O.C.N	√I.E.			Janua	ry 29, 2011	I	
		30. Name and address of person who comp			,			o	h:		•			
			32. Registrar			900 W. Bal	-	Street, Ba	itimore	e, MD 212	23			
St Pegist	ate	31. Date filed (Month, Day, Year)	52. registral	o orgrature	6	backet	,							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ELIZABETH FRANCES COSTER Feb Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Madonna Heritage Jarrettsville Harford 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 💥 F Days Months Hours Min. Indiana 216-34-6810 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD. Harford Pylesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1013 Harkins Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Specify: Year or Dates. White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname William Brocklehurst Ruth Frances Comoton 19a. Informant's Name/Relationship (Type, Prigon-in-la 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Joseph C. Butler Jr. 3859 Federal Hill Rd. Jarrettsville, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I-Important: If ite any injury or otl 20c. Location - City or Town, State Feb. Date 9. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) arrettsville Cem. Jarrettsville, MD 21. Signature of Funeral Service lie 22. Name and Address of Facility E.G. Kurtz & Son Funeral den Jarrettsville, Maryland P.A. Home. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ Vaha drahon disease or condition resulting in death) week Medical Due to (or as a consequence of): Examiner Panoint 100 mon xa Sequentially list conditions. if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Demen tin attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month 4 Pregnant at time of death Day the a 9 Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Darkinson's disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ruphured brain aneurysims 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Dicheks performed Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕱 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work 2 Accident Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. only one ed at the time, date and place, and due to the cauce(s) and mainler as stati

Division of Vital Records, P.O. Box 68760 To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completed filled in by the 29b. Signature and title of certifier 29c. License number D37,295 2/4/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendy Kloesz MO 5781 Kenwy of Aul Bostomere mo 21200 31. Date filed nth. Day, Year) 32. Resistrar's Signature **State** Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year MERRIE BYRD COLLINS 2011 Medical 8:40 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Year) 06-11-1943 Director Yrs. SOUTH CAROLINA 67 <u>250–68–6092</u> Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No VIRGINIA PRINCE WILLIAM MONTCLAIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5618 RHAME DRIVE 22025 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced Completed er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. sant: If item 27 is marked other than ury or other traumatic event, the M College (1-4 or 5+) ACCOUNT CLERK PRINCE WILLIAM COUNTY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HILTON PRESTON BYRD MARGIE_GRIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES COLLINS - HUSBAND 15618 RHAME DRIVE, MONTCLAIR VIRGINIA 22025 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If ite
any injury or of 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) QUANTICO NATIONAL CEMETERY 2-2-11 TRIANGLE, VIRGINIA 21. Signature of Funeral Service Lice 22. Name and Address of Facility MOUNTCASTLE TURCH FUNERAL HOME, 4143 DALE BLVD.VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 🔀 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las autopsy performed? certificate ! Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မြ 1 🗌 Yes 2 😾 No After this 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending neral Director: A Investigation 1 \square Yes 2 🗆 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours a the Funeral D Medica 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101236858 (VA)

State

101

Registrar

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MC

USN

LCDR

COREY CARTER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23^{Day} 201^{rea} PRICADIZ January 11:27a M Derev Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death College View Center Frederick Frederick Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1910 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🏻 F Months Hours Ukraine Director 219-27-4489 100 Usual Residence of Deceden fshow 10a, State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1513 Rising Ridge Road 21771 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Midowed 4 ☐ Divorced Completed Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Pharmacist Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ should be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Tatyana Velichko /Granddaughter 1513 Rising Ridge Road, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 1/26/2011 Frederick, Maryland 21. Signatur \$2. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -₽hysician/ Jementia disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner rabable Breas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury equentially list conditions Examiner Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year I signed by the a 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I autopsy perform death? performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 1 No Other မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Lursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours 24 hours Funeral leted filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, D60417

State

Registrar

TOHNSON

Dr

nomus

strar's Signature

Frederick MD 21702

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen 31. Date filed (Month, Day, Year)

Alfred Drew		Please Tyj St - For State	e or Prir ate of Ma		Depa	rtment	of He	alth an				gible.	2011	04122					
	F	Registrar			Cer	tificate	or De	atn		1		eg. No.		2 Toronto					
Physician Medical Examine	~	1. Decedent's Name (First, Midd								ľ	2. Date of Deal Month February 5		Year	3. Time of Death 1513 hrs					
ineulcai Examine		Alfred Drew, 4a. Facility Name (if not institution		nd number)			4b Cit	v Town or	Location of	Death	rebruary :		County of Death						
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Funeral	4	5. Social Security Number	6. Sex	7. Age	(In yrs. la	st birthday) If U	nder 1 Yea	r If Under	24Hrs.	8. Date of Bir	th (MM/D	D/YYYY) 9. Bir	thplace (State or					
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kur	-	10a. State 10b. County		П	10c. City,	Town or Lo	cation							10d. Inside City Limits					
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d be fill fental larked event,	١	Alfred E. Drev 19a. Informant's Name/Relations		`		10h Ma	ilina Addre	es (Steen					or Tourn State	Zin Codo)					
MD 21 d 2 should th and Me n 27 is ma n mmatic cv	-	Carolyn Brown	daught					-			MD 215		or rown, diate	State, Zip Code)					
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t. Partmen	Ь	4 Donation 5 Other State 21. Signature of Funeral Service	ecify:		le co		_	nd Address		_			<u> </u>						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menal Hygiene. Department of Health and Menal Hygiene. I fine 23 a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	П	Man 3M Source	Licerisee	moos	747					Sowe	ers Fun	eral	Home,	P.A.					
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Division of Vital Records, but or Attending Physician: The law require and after death. After this certificate has been silled in by the funeral director, page 2 should be artification: To Re Commistered		1 Yes 2 No 27. Manner of Death	28a.	Date of Injur		28b. Time			y at Work?		8d. Describe h			. Scelle					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring dedical Certification: To Re Commisted by Physician/Medical	3	one) 2 Medical Exa	niner:On the b	asis of exam															
To To So	È :	29b. Signature and title of certifie		ner stated.			2	9c. License	number			29d. Da	ate signed (Mor	ath, Day, Year)					
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0,	1	30. Name and address of person	who completed	cause of de	ath (Item 2	23a)													
81		Pamela E. Southall, M	-				00 W. E	Baltimore	Street, I	Baltim	ore, MD 21	223							
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Registra	il.																		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, January 2011 1:45 p Burke Engman Larry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Sept 3, 1936 1 🖾 M 2 🗆 F Months Hours 294-30-5820 Ohio **Director** Usual Residence of Decedent f show 10b. County should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director MF) Silver Spring Montgomery 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1525 Gridley Lane 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1956-57 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Case Officer C.I.A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Melvin Bertel Engman Edna Rose Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1525 Gridley Lane, Silver Spring, MD 20902 Rosemary D. Engman/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 k Cremation 3 Removal from State Jan. 28 2011 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spr 21. Signature of Funeral Service Licensee MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examine MRSA Pneumonia 2 wks Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of tending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant
Unknown 5 Other (specify) Month Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Lunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' tor: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🔲 Yes 2 🔼 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jan. 26, 2011 MC D35112

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, MD 20910 Paul Bauer, MD

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

	1- For State Certificate of Death Reg. No.															
Physicia	_	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 3.												3. Time of Death	П	
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F	4	Social Security Number	6. Sex	7. Age (In yr	e last hid	thday)	If Under	r 1 Year	If Under	24Hrs	8 Date of F	pplace (State or	\dashv			
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.	1	10 Park Park Park Ordeland											g. MD 2087	7		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical		miner:On the basis		nialiu/0i	vesugati				anou at	ore unie, dal					Ц
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	ŀ	30. Name and address of person	who completed ca	use of death (I	tem 23a)											٦
		Carol Allan, MD As	sistant Medica	ıl Examiner	900	W. Balti	more S	street, E	3altimo	re, MD	21223					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Miriam Easton 2011 January 955 PM Medical 4a. Facility Name (if not institution, give street and number) The Hebrew Home of Greater Washington 4c. County of Death Montgomery 4b. City, Town, or Location of Death Rockville Examiner Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York, NY **Funeral** 8. Date of Birth 1 □ M 2X F Days Hours Min (Month, Day, Year /29/1918 Director 055-10-0506 Usual Residence of Decedent show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Mediral Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Julius Berger Bertha Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Thomas - daughter 10401 Grosvenor Place #1220 Rockville MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 1/27/2011 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville MD 20852 M01163 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Dements Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uiscase or immunity) Examine Due to (or as a consequence of) and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 2 X No Yes 2 No 1 Tyes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 2 🔀 No Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier miron Jan le 3 D0064871 1-24-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mina

31. Date filed (Month, Day, Year)

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Registrar's Signature

Rd

Rockville,

2080

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 2011 6:00 p ^M Lizzie Echols January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital <u>Olney</u> Montgomery County Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min. 1 □ M 2 😾 F 12-26-1926 Alabama Director Yrs. 253-22-3884 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 XYes 2 No Md Montgomery Silver Spring ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12625 Layhill Road, #102 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian injury or other traumatic event, the Medical Examiner Black, White, etc. 9 Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than Elementary/Seconday (0-12) College (1-4 or 5+) Private 5th Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental i marked o မ Lawrence Bennett Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health in item 27 12625 Layhill Rd., #102 Silver Spring, Md. 20906 Joseph P. Freeman, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Riverdale Park Crematory 1-13-2011 Riverdale, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor, II Funeral Home ay Blerron 10583 Middleport Lane, White Plains, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one is use on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other; 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After the 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 \square Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 Day Physician/ Month January 2011 Fishbeyn 10:37 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 95 Dawson Avenue #408 Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Sex 1X M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Ukraine Hours 01/27/1926 Director 020-72-8866 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked of then than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 95 Dawson Avenue #408 20850-1885 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify 3 🕅 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Physcian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Victor Fishbeyn Ethel Gulko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vitaly Fishbein - son 2 Fawn Drive Livingston NJ 07039 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 01/21/2011 Donation 5 Other (Specify) Parklawn Mem. Park Rockville, MD 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville MD 20852 Signature of Fuperal Service Licensee M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Lymphoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): g physician and as the burial-ransit Examir death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 ned by the attending p detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Completed filled in by the funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director director, the funeral director director, the funeral director director, the funeral director director, the funeral direct Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? X Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00531 M.O January 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 30^{Day} , 2011 Rachel Pauline Ford January 7:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17500 Stone Valley Drive Washington County Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 I Months Country 215-26-8577 Director 79 Time Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Washington Co. Hagerstown 1 ☐ Yes 2x1x1 No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 17500 Stone Valley Drive 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Operator Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be J. Donald Murray Laura I. Nave Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4629 Copper Lane, Plant City, David E. Ford II Florida 33566 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o 1 M Burial 2 Cremation 3 Removal from State Rose Hill Cemetery Feb. 3, 2011 | 4 Donation 5 Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Eastern Blvd. N. Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Metastatic Scindle Cell Sarcoma
Due to (or as a consequence f): Physician. eat disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to force a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death' 2 🗌 No 1 🗌 Yes ☐ Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 욛 4
Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ■ Residence 6 □ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Matural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) DYTYS ynthea Kuther - Sands no January 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) as hing ton County, CInthia Kuther-Sands, no Hospice of Washington Havers to

DHMH 17 Rev 7/2009

State Registrar 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 20, 2011 Marcella Fuel1 January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7324 Donnell Place, Apt B-1 Prince Georges District Heights, MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 ☐ M 2 🗓 F 4/13/1936 Gaffney, SC Director 242-54-1852 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Prince Georges 1 □XYes 2 □ No District Heights Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7324 Donnell Place, Apt B-1 20747 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21🛣 No Specify. Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Correctional Officer DC Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marlane Davis ပ Pittman Camp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Park

Physici /Media

the Maryland

Saltimore, Maryland 21215-0036

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Medical kaminer	
caminer	
See	ē
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical Certification: To Be Completed by Physician/Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

death. 4 hours after death.

24 hours a Hospital

P.O. Box 68760.

Division or Vital Records,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier and manner stated. 29c. License number

ns that caused the death. Do not enter the nuse on each line.	node of dying, such as cardiac or	respiratory arrest,
MANANA	STOMPLH	CANCER
Due to (or as a consequence of):		
Due to (or as a consequence of):		
Due to (or as a consequence of):		<u> </u>

22. Name and Address of Facility
Pope Funeral Homes, P.A.

4425 Rena Road #T3 Suitland, Maryland 20746

1/31/2011

5538 Marlboro Pike, Forestville, MD

23d. Date of delivery Month

> 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes

20c. Location - City or Town, State

Riverdale, Maryland

20747

Approximate Interval Between Onset and Death

24a. Was an autopsy performed 1□ Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier VENKAIRIMA

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) > 304) HANNER &

31. Date filed (Month, Day, Year)

Melody Harrod / Daughter

4 ☐ Donation 5 ☐ Other (Specify)

23a. Part1. Enter the disease, or complice shock, or heart failure. List only one

21. Signature of Funeral Service Line ann

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

20a. Method of Disposition

32. Registrar's Signature

Registrar

State

DHMH 17 Rev 1/2001

Registrar

SHORE DRY SAUSBURY MD 2/804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

910

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 24, 2011 3:50p [™] January Greenberg Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Arden Courts Potomac Montgomery 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. 1 🗆 M 2 🗓 F Months Pa. 89 Yrs. Director 137-14-2039 Usual Residence of Decedent l Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🛣 Yes 2 🗆 No Md. Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 US 5600 Wisconsin Ave. Apt. 405 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: Specify: White 3 x Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Researcher Smithsonian Association 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked off any injuy or other traumatic even one. 2 Harry Halpern Cecelia Margolis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Shapiro/Daughter 5620 Grove St. Chevy Chase, Md. 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 😾 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) King David 1/28/11 Falls Church, Va. 21. Signature of uneral Service Licensee 22. Name and Address of Facility Danzansky Goldberg Memorial Chapels 1170 Rockville Pike Rockville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. Myocardial Infarction Minutes Medical resulting in death) Due to (or as a consequence of) **Examiner** Diabetes Mellitus <u>Years</u> Sequentially list conditions, if any leading cause. Enter Underlying Examine physical stansit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Id be detached for Yes 2 🔀 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia this certificate has ral director, page 2 performed Hyper Lipidemia 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) assisted living 1 Tes 2 x No မြ 1 Inpatient 2 Inpatient 3 Inpatient 2 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 덡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 1/25/2011 D3A590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Roy Fried MD 7758 Wisconsin Ave. #211 Bethesda, Md. 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	arylan	•				lental Hy	giene	2 12				
	_		1 - State Registrar	-4)		Cei	tificate	of Deati	h		Reg. No.	20		04 (33	
П	Physicia		1. Decedent's Name (First, Middle, Las	Gent	h.	0/				2. Date of Dea	ath Day	2-7	Year	3. Time of Dear	th M	
***	Medic Examir		4a, Facility Name (if not institution, give		, , , ,		4b. City, To	wn, or Locati	on of Death		4c.		∂ 0 (/ of Death	, 130		
-			Delmana 1-	eart			SA	11	M		WICOMICO					
	Funeral		5. Social Security Number 6. S	ex 7. Age	.)	ast birthday)	If Under 1 Months [Year If Uni	der 24 Hrs. rs Min.	8. Date of Birt (Month) Da		9. Birthplace (State or Foreign Country) MD				
	Director		213-56-4690 1 Usual Residence of Decedent	74=	62	Yrs.				10/2	94	8		- PID		
	show dat	for	10a. State 10b. County		10c. City	y, Town or Lo	cation						10	d. Inside City Lir	mits	
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	al D	10e. Street and Number 230 West Stree	_ 4_			10f. Zip C 218				10g. Citi		/hat Count	ry?		
	ath wi	Funeral	11, Marital Status	12. Was Decedent E	er in 115	113 1			Origin? (Spe	cify Yes or No-			- America	n Indian		
ဖွ	or ite		1 Never Married 2 Married	Armed Forces?			f Yes, specify	Cuban, Mexi	ican, Puerto F			Black	k, White, et	tc.		
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g	filed valued by dothe		17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden S	urname,)			
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Maryland 21215-0036	2 shou h and 7 is n		19a. Informant's Name/Relationship (7			19b. Mailir	ng Address (S	treet and Nur	mber or Rural t - Be	Route Numbe rlin,	r, City or 1	Town, St 21	tate, Zip Co 811	nde)		
ē,	Health tem 27		Kathleen P. Ge 20a. Method of Disposition	Ittiller	20b. P		sition (Name		1	ate	20c. Lo	cation -	City or Tov	vn. State		
mo	Page nent of ant: If ury or		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	Fir	emetery, cren St St	natory or other cate (cr ^{place)}		/2011			oro,			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens			22	. Name and	Address of Fa	cilityThe	Burba et, Be	age.	Fun	eral	Home 21811		
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١			23a. Paft 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	plications that caused ine cause on each line.	the death	n. Do not ente	er the mode o	f dying, such	as cardíac o	respiratory an	rest,			Approximate Interval Between Onset and Death		
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3760	ficate g physas the	/edi		d												
ŏ ×	endin r use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of			Ectopic pre	gnancy			2		e of deliver	*		
P.O. Box 687	e deat the att ned fo	Completed by Physician/Me	1 Pes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of d	leath 5	Other (spec	ify)				Mor	nth [Day Year		
Ö.	hat the ed by detacl	y Ph	Part II. Other significant conditions c	ontributing to death bu	t not resi	ulting in the u	nderlying cau	se given in P	art I.	23e. Did to	bacco us	se contri	bute to the	cause of death?	?	
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Division of Vital Records,	Atter	Certificate:	3 Suicide 6 Could not b				eet, factory, o	ffice	2	28f. Location (S		Numbe	r or Rural f	Route Number,		
<u>S</u>	ital or urs aft ral Dir lled in									City or Tow						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	sician: To the best of n iner: On the basis of ex-	amination	and/or invest	igation, in my	opinion, death	h occurred at	the time, date a	nd place,	and due	to the caus	se(s) and manner	stated	
	To the within To the compl	Σ	only one) 3 L Certifying Nurs 29b, Signature and title of certifier	se Practioner: To the b	est of my	Knowledge, C		cense numbe					(Month, D			
), 3	2		MO		1741	150	5		1/2	-71	11		
	001		30. Name and address of person who d	completed cause of de	ath (Item	23a) (Type, P	rint)	.1-1		~~		~ 11	2011	3		
	BA 6 Stat		31. Date filed (Month, Day, Year)	32. Registrar	's Signat	ure .	<u> </u>	alis	bung	M) (d 19	804			
	State State		IAN 21	2011		1 1	bon Ned	•	•							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04134 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JANUARY 2011 Physician/ 11:55P M CLIFFORD FREEMAN GRADY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral Days Min. 9/15/1939 1**X** M 2 □ F Mt.Olive. NC Director 246-60-7883 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c., City, Town or Location 10d, Inside City Limits Examiner must be notified at Director Maryland Frederick Frederick 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ō Funeral items 23a 100 Burgiss Hill Way, #308 21702 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 9 ģ 1 Never Married 2 Married 1 ☐ Yes 2x No Specify: Specify: Black "natural" Completed 3 ☑ Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Retired Teacher Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Clifford Freeman Grady, Sr. Mamie Winn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 Shaker Lane, Frederick, MD Cheri Tolson-Clipper / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other placel 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wayne Memorial Cemetery 1/19/11 Dudley, N. Carolina 4 Donation 5 Other (Specify) Signature of Licensee 22. Name and Address of Facility Pope Funeral Homes, PA rymons arr 538 Marlboro Pike, Forestville, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Physician/ DAYS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner COLON CANCER METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner death certificate be executed Due to (or as a consequence of): physician a s the burial-Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certification DO061410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 FOLL HOUSE AVE, FREDERICK, MD

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 23 State of Maryland, Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 420 Theresa Jean Haines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WHMS-Regional Medical Center Cumber land 8. Date of Birth
(Month, Day, Year)
Nov. 13, 1 . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - TF Hours Mary Tand 218-60-2315 Director 58 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director WV Mineral Ft. Ashby 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be USA Funeral 26719 PO BOX 841 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 🄀 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Home **HOmemaker** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruth Annabelle Poling Robert Sloan Peer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 841, Ft. Ashby, WV permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. Michael A. Haines 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Feb. 3,2011 Springfield, WV 4 ☐ Donation 5 ☐ Other (Specify) Springfield Hill 22. Name and Address of FacilityShaffer Funeral Home, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WV Approximate Interval Between Onset and Death 23a. Part 1. Enter the Immediate Cause (Final Ph sician/ Shock disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respirator Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of the burial physician **Diverticulitis** Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached f the ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **N**0 Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 \square Pending 24 hours after death. Funeral Director: A ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ardulan Enkeshof: 12501 willow brook road, Cumber land, MD 31. Date filed (Month, Day, Year)

FEB14

32 Registrar's Signature

park

00068 455

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Hromulak January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Laurel Regional Hospita George's aure Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Allg. 11, 1916 1 □ M 2 😾 F Pennsylvania Director 162-16-8700 94 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1X Yes 2 □ No Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Ridge Road, #T-2 20770 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Tkach Andrew Fetsko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5006 Stewart Court College Park, Maryland 20740 Richard Holt -son in law 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 1/24/2011 SilverSpring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Bonard V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. Dementia Severe disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner neumonia Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Sepsis To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death safter death.

I Director: After this certificate has been signed by the £ d in by the funeral director, page 2 should be detached ¹ g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, January 20, 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital George I, OKang, MD

State

Registrar

31. Date filed (Month, Day, Year)

JAN

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea Physician/ Dona1d Hammersla Janua 26 Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Washington Hagerstown 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day,)
July 18, Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 🛛 M 2 🗆 F Director 220-28-3847 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than 27 is marked other than "---10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 18428 Breathedsville Road 21713 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces? 1 X Yes If Yes, Give 1 Never Married 2 Married 2 No 1951-1 ☐ Yes 2 X No Specify: Specify: 3 🕅 Widowed 4 □ Divorced White 1959 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Driver 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Russell Helen Daley Edward Hammers1a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Mills Road Sharpsburg, Donald J. Hammersla, Jr. Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Samples Manor Cem. 01-30-2011 Sharpsburg, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA . Signature of Funeral Service 7606 Old National Pike, Boonsboro, MD 21713 23a. Part / Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or seconsequence of): Approximate Interval Between nset and Death one week Physician/ Medical Examiner week umon Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Yes 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 s autopsy perforn msc1 1 Yes 2 No 25. Was case referred to medic examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

Re Funeral Director: A pleted filled in by the fu Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c, License number 2011 44996

State

Registrar

31. Date filed (Month, Day,

Fegistrar's Signature

Boonsboro

30. Name and ageress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 2011 11:46 Physician/ A_{M} OLIVER THEODORE HAND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 ☑ M 2 ☐ F May 19, T923 West Virginia 553-34-0256 87 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Frederick Thurmont 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a o Funeral United States 21788 15721 Kelbaugh Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 \times Yes 2 \square No If Yes, Give 1941-64 Year or Dates. X Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) United States Army Warrant Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Marie Danielson 2 Oliver Walter Hand 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12818 Boxwood Lane, Union Bridge, MD 21791 Donald Hand / Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date . Jan. 1 Burial 2 Cremation 3 Removal from State 2011 Baltimore, Maryland Greenmount Crematory 4 Donation Other (Specify) 21. Signatur f Funeral Ser e Licensee Resthaven Funeral Services, Skkot Cody P.A. MD 21701 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the diseas shock, or neart failure Immediate Cause (Final disease or condition resulting in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ Probable Medical Due to (or as a consequence of) ≟xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) ☐ Pregnant ☐ Unknown Pregnant at time of death should be detached ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementia 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? preumonla 24a. Was an this certificate has autopsy page 2 Yes 2 No 1 Yes 2 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be Hospital 10 1 ☐ Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After iniury 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: Al Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practicular: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signature 29d. Date signed (Month, Day, Year) 27/2011 MUD 35267

State Registrar 400

32. Registrar's Signature

74h St

Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 24, Physician/ 2011 11:30 a.M Brunhilde M. Hickey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Northampton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe **Funeral** 1 M 2 X F Months Days Hours 10 19 7 19 19 Germany **Director** 568-46-5190 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 🗌 Yes 2 🏞 No Frederick MD Frederick 10f. Zip Code 10e Street and Number 0 10g, Citizen of What Country? ar than "natural", or items 23a or the Medical Examiner must be Funeral USA 8626 Pinecliff Dr. 21704 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired College (1-4 or 5+) Elementary/Seconday (0-12) own home homemaker er rit. Page 1 and 2 should be filed with egratment of Health and Mental Hygier uportant: If item 27 is marked other tony injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ida Strahschmidt Hans Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8626 Pinecliff Dr., Frederick, MD 21704 Christiane Shearer-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Termation 3 Removal from State cemetery, crematory or other place, 01/25/2011 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) per nit. I Der artm Importa any inju . Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -h sician/ neumonia Laus disease or condition Medical resulting in death) Due to (or as a consequenc Af) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Var Kinsons Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title -26-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Miller MD 4 Culwell Dr., Mt. Airy, MD 21771 31. Date filed (Month, Day, 32. Registrar's Signature State Museum Registrar

State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year MARY LOUISE 0:05P TANTIARY Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Month, Day, 1 🗆 M 2 🔀 216-22-0821 83 1928 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Md. Frederick Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1004 Lindfield Drive 21702 United States Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or i þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White I Hygiene. other than "natural", Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home h and Mental Hygien 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Emma Oursler Robert H. Kruhm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frederick Md. 21702 19a. Informant's Name/Relationship (Type, Print) Linda S. Howell / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite Date cemetery, crematory or other place 1

■ Burial 2

□ Cremation 3

□ Removal from State 1/26/11 Laytonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Laytonsville Cem. Name and Address of Bacility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 21. Signature of Funeral Service Licenses 20882 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner 05 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: " use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page performed 2. No Yes 2 N 1 Tes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 \square Yes ပ္ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide (Month, Day, Year) 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Tecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) D0055061 Aubrie Jacobson Nagy, M.D. 30. Name and address of p who completed cause of death (Item 23a) (Type, Print) treet Nes int 31 Date filed (Month 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State of Maryland / Department of Health and Mental Hygiene / U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HERNANDEZ 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORS UNIVERSITY OF MD MEDICAL CENTER if Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Country) DC Days Hours 1 □ M 2 □XF 012-12 22-1997 577-29-5434 Director 13 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director Hyattsville MD Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 20781 4709 40th Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 □ No Specify: El Salvad. Specify: Hispanic 3 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8 t h College (1-4 or 5+) School Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Enna Hernandez Marcos Zelaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $4709\ 40th\ Ave.,\ Hyattsville,\ MD\ 20781$ Marcos Zelaya/Father Baltimore, 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Silver Spring, MD 01-31-201 4 Donation 5 Other (Specify) Gate of Heaven 20746 Signature Funeral Service Licenses 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave.,Suitland, MD M01368 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ AnoxIC disease or condition brain Medical resulting in death) Due to (or as a consequence of) Examiner 5 days Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Year 1 ☐ Yes ∠ № 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N ours after death.

Gral Director: After this certificate I filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No 1 ♥ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 ☐ Yes 2 🗷 No House fire 0400 AV 19/2011 Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4709 40th St Hyattsville Home To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ap 241707 201 BUNIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 ST, BALTIMORE MD JESSICA BUNIN 22 SOUTH GREENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

04142

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2^{Day} **Physician** 2°0°11 IRENE HIGGINS 1:55 а м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 32510 WEST POST OFFICE RD. SOMERSET PRINCESS ANNE Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Yrs. Director 138-26-9964 7.7 08-30-1933 NORTH CAROLINA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Me. it at Examinar must han a contract the mean in the market has a contract to the contract has a contract to the contract has a contract to the contract has a con 10c. City, Town or Location PRINCESS ANNE 10b. County SOMERSET 10d. Inside City Limits 10a. State MD • 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 32510 WEST POST OFFICE RD. 21853 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SEAMSTRESS CRAFTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLIE NORWOOD BERNICE GIBSON NORWOOD ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10480 PERRYHAWKIN CHURCH RD., PRINCESS ANNE, MD. JOHN RICHARD HIGGINS JR. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 01-29-2011 ST. JAMES CEMETERY WOODBRIDGE, NJ. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINMAN FUNERAL HOME 21. Signature of Funeral Service Licensee MO0295 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imperiate Cause (Final discusse or condition **Physician** netastatic yeer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 □ No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.O. 030690 Jan. 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Corroll St. 501.530ry MO 2180, Jones 100 E. MARTIN 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

JAN 28 2011

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** 02 07 2011 1680 Betty Ann Hanna /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 104 Wright Street Allegany Frostburg 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🖫 F Director 214-28-6331 08-08-1932 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Experiment be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Wright Street U.S.A. Funeral 21532 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ulysses Hanna Ethlyn Hughes Hanna ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Gary Hanna nephew 101 Summit Place Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 02-10-2011 Frostburg, MD 21. Signature of Funeral Service Licensee Sowers Funeral Home, P.A. Han M00547 1-Sowers 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Cly romic obstructive 6morth /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed after death. ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by cate has been signi page 2 should be a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy this certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ∏No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wonsochshin MP 00055324 Feb 08,2011

10

State Registrar

DHMH 17 Rev 1/2001

925 Bishop Walth Rd Cumber land MD21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** THOMAS WENDELL HARLEY FEB. 5 2011 12:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CHARLES LA PLATA 6735 FRIENDLY OAK PLACE 8. Date of Birth (Month, Day, Year)

JUNE 18,1950 If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1**X** M 2 □ F 215-50-2817 WASH.,DC Director 60 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h County 10c. City. Town or Location 23a or 28a-f show or other traumatic event, the Medical Exp. inserment be notified at Director 1 ☐Yes 2 XNo MD CHARLES LA PLATA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. 6735 FRIENDLY OAK PLACE 20646 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. AMERICAN Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or ite 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐Yes 2X No ģ 3 Widowed 4 Divorced INDIAN Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) P.G.COUNTY SCHOOLS BUILDING SUPERVISOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES MELVIN HARLEY SR. MARY LILLIAN BURCH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a
Important: If Item 27 Is
any Injury or other trau 5905 BUMPY OAK ROAD LA PLATA, MD 20646 RANAYE HARLEY/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEBRÜARY 1 Burial 2 Cremation 3 Removal from State ST.JOSEPH'S CEM. 9,2011 POMFRET, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONCO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only ope) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No death. investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** SARAH HESS HENINGER 7:30A FEBRUARY 2011 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES 14815 KING CHARLES ISSUE DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | JAN 1 1 1923 5. Social Security Number 9. Birthplace (State or Foreign Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F PENNSYLVANIA 221-14-0550 88 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 2 should be filed within 72 hours after death with the Marylar is and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show raumatic event, it is fined to be a filled to a fi 1 ☐ Yes 2 No Director MD CHARLES NEWBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14817 BANKS O'DEE ROAD 20664 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. txtxes 2 No If Yes, Give Year or Dates: 43 − 47 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No 2 SpecifyWHITE 3 ☐ Widowed 4XX ivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. GOVERNMENT TELEPHONE OPERATOR 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be IRMA HESS WARREN HESS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN W. KEMPF/FRIEND 14815 KING CHARLES DR. ISSUE, MD 20645 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FEBRÜARY 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO.CREMATORY 7, 2011 ALEXANDRIA, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 on 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate clause the discounting Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): signed by the attending physician dbe detached for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? durgives -Be 26. Place of Death (Check only one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 😿 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **+** ☐ Natural 1 ☐ Yes 2 ☐ No Il Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

P.0. Division of Vital Records, or Attending Physician: hours after death. To the Hospital

within 24 hours a

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Georgann Kracher Juneau 29. 2011 7:51 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. 27, 1934 1 🗆 M 2 🔀 F Months Days Hours Country D. C. Director 220-34-4634 76 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗌 Yes 2 🍱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10619 Ordway Drive 20901 USA ıral", or item I Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ρ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Smithsonian Institute Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ည Victor C. Kracher Julia L. Byron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Vicki Juneau Ruane/Daughter 10619 Ordway Drive, Silver Spring, MD 20901 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or or ☐ Burial 2X Cremation 3 ☐ Removal from State ^Jan₁₁³¹, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Ever the disease, or complications that press, the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Septic Shock Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Dementia that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial physician Physician/Medical Dystonia Box 68760 the attending IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 1 Yes 2 X Pregnant at time of death 5 Other (specify) Day Year signed by the ar P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Cerebral Palsy 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifies **Division of Vital** 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 xxNo မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ceptifying Nu rse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) D41624 Jan. 29, 2011 30. Name and address of person who comp cause of death (Item 23a) (Type, Print)

State Registrar Guy P. Murphy, MD

Day, Year

3. Registrar's Signature

1500 Forest Glen Road, Silver Spring, MD 20910

11-00202 Alitha Mae Jenki	ns	Please Type or P	rint in Black Indeli	ole Ink. Ensure All Copent of Health and Mental	ies Are Legibl Hygiene	e. 2011 04147						
Alitia Mac ocina		1- For State Registrar	Certifica	ite of Death	Reg. No.							
Physicia	an/	Decedent's Name (First, Middle,Last)			Date of Death Month Day	3. Time of Death 0828 hrs						
Medical Exami	ner	Alitha Ma 4a. Facility Name (if not institution, give stre		4b. City, Town, or Location of Dea	January 7, 201	4c. County of Death						
		1700 blk Olive Street	et and number)	Cheverly		Prince George's						
Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. last birth		lin. Oct. 6,	M/DD/YYYY) 9. Birthplace (State or Foreign Country) DC						
ž.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits						
ow any			, ,	Lando	over	1 X Yes 2 No						
Maryland 28a-f show d at once.	ctor	Maryland Prince Geom	ge_s	10f. Zip Code		itizen of What Country?						
he Ma 1 or 28	Director	2441 Kent Village	Place	20785	1	United States						
with 1 ns 234 be not	ral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.						
death nr iter must	Funeral		Yes 2 X No	_	, ,	Specify: Black						
s after rral", niner	ģ	3 Widowed 4 Divorced of F or I or I or I or I or I or I or I or	ates:	1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind	of work done 16b.	Kind of Business/Industry						
2 hour	Completed			during most of working life. DO NOT use								
036 ithin 7 ne.			4	Unemployed		none						
215-0036 be filed within 7 ntal Hygiene. rked nither than		17. Father's Name (First, Middle, Last)			me (First, Middle, Maide Carrie Bell							
2121 2121 Umental marked	Be C	Leroy Jenkir 19a. Informant's Name/Relationship (Type,	City or Town, State, Zip Code)									
MD 2 id 2 shoul lith and M m 27 is m	To	Tris Jenkins - Da	To the second se	441 Kent Village P								
e, N l and 2 Health item 2		20a. Method of Disposition	20b. Place of	f Disposition (Name of cemetery,	Date 200	c. Location - City or Town, State						
nor ages lant of l		1 X Burial 2 Cremation 3 F 4 Donation 5 Other Specify:	Removal from State	Heritage rial Cemetery	nuary 15, 2011	Waldorf, Maryland						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiers, Important Sittem 71 is marked nither than "natural", ur items 23a or 28a-f sho injury ar nither traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Lice Lee	THEMO	22. Name and Address of Facility S								
	3 3	4001 Benning Road NE Washington, DC 20019 284 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Petropo Operatory										
Physician /Medical		failure. List only one cause on each li	ne.	of enter the mode of dying, such as cardia	ic or respiratory arrest, s	Between Onset and Death						
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
		h	to (or as a consequence or).									
	ner	Sequentially list conditions, if any, leading to immediate Due cause. Enter Underlying Cause										
	xaminer	(Checked in injury that initiated	to (or as a consequence of):									
executed an and al - transit	ш.	d	<u></u>									
e execcion a	dica	UNPENDED	MENDED									
Box 68760, death certificate be the attending physic ed for use as the bur	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the	3c. If yes, outcome of pregnancy Live birth	Fetal death 3 Ectopic pre		23d, Date of delivery Month Day Year						
K 68 1 certif ending use as	ciar	1 Yes 2 No 9 V Unknown 9 Unknown										
Boy e deatl the att	hys											
P.O. es that the gned by	by P											
S, F quires en sign	ted				24a. Was an	I 24b. Were autopsy findings available						
tord aw re- has be 2 shou	를 				autopsy performed							
ivision of Vital Records, P.O. Box 68760, In Attending Physician: The law requires that the death certificate be execute after death. The the this certificate has been signed by the attending physician and din by the funeral director, page 2 should be detached for use as the burial - trar	Completed	05.44		26.Place of Death (Ch	1 Yes 2	No 1 Yes 2 No						
Division of Vital Rec al ar Attending Physician: The I as after death. Il Director: After this certificate I ed in by the funeral director, page	8	25. Was case referred to medical examiner?	oital: 1 Inpatient 2 ER/0	lau .		sidence 6 🗸 Other: Scene						
Of V g Phys fer thi	[은	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	Time of Injury 28c. Injury at Work?	28d. Describe how							
On (cnding ath. yr: Af	ertification:	1 Natural 5 Pending		JND: 1 Yes 2 ✓ No	Subject was as	priyxialeu						
Division Safter death. In Director: /	ifica 	2 Accident Investigation 3 Suicide 6 Could not be		arm, street, factory, office building, etc.	or Town, State	et and Number or Rural Route Number, City						
E I E I L	1 5	4 Homicide determined	(Specify) Local Street		1700 blk Olive Street, Cheverly, MD							

Div To the Hospital n within 24 hours aft To the Funeral D

4 V Homicide
2 Check only one) 2 V
29b. Signature and Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 8, 2011 O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who complete causs of the (Item 23a) Deputy Chief Medical Examiner Mary G. Ripple MD.

32. Registrar's Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Julia Μ. Johnson 2011 11:15A Medical Tanuary 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7501 Greer Court Washington 9. Birthplace (State or Foreign Country) Fort Prince 8. Date of Birth (Month, Day, Year) If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1 □ M 2 😾 F **Director** 577-28-7295 10. 1918 Mav NC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant I frem 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Washington Fort 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's Completed by Funeral 7501 Greer Court 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 2 **X**No Yes Maryland 21215-0036 Specify: Black If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) of Army Retirement Analyst Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Milton Roberts Richmond Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7501 Fort Court Greer Jacqueline Jackson/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 1/28 / 11 4 Donation 5 Other (Specify) Maryland National Cemetery Laurel, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause up each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a polyseque, re-of-To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 1 L Yes 2 L 9 Unknown has been signed by e 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **Y**No Hospital: မ 1 Inpatient 2 I ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral director. 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Janonth Physician/ 25, Day 201 1 ar 20:27 P M James Michael Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clinton, Maryland Prince Georges Southern Maryland Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Mayont 2 3ay, Yel 948 093-40-9886 1 👿 M 2 🗆 F 62 Director tharleston. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.
Important: If tiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Suitland Maryland X□ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4180 Suitland Road, #401 20746 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ğ 1 Never Married 2 Married 1X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Mail Handler U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Michael Marie Johnson 19a. Informant's Name/Relationship (Type, Print) Vanessa B. Johnson / 19b Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 4180 Suitland Road, #401, Suitland, MD 20746 Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Lincoln Memorial Cemetery 2/2/11 |Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Forte Funeral Homes, PA 5538 Marlboro Pike, Forestville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ANCEIZ Medical resulting in death) Due to (or as a consimence of): Examiner Obacco Sequentially list conditions, if any least to immediate cause. Enter Underlying Cause (Disease or linjury Dia- to for as a gonsection of Exami ypertens physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 1 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0:45 PM MARION GLENDENE JOHNSON 201 ENTUCIT Medical or Location of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town County of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign ge (In yrs. last birthday) **Funeral** 1 □ M 2X F 76 Hours Min. 2 Month 5 Day 1 Year 3 4 WCOVTA. 234-52-5676 Director Usual Residence of Decedent any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director PORT TOBACCO 1 🗆 Yes 2 🖁 No MD. CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20677 7910 PORT TOBACCO ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No ģ 1 Never Married 2 Married Specify:WHITE 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) COLLEGE OF SO.MD. FINANCIAL AID and Mental Hygie is marked other Be pe filed 117. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GLADYS SHOCKEY ANTHONY F. PRITT permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1013 MADISON LANE FALLS CHURCH, VA . 22046 DELORES CRAWFORD-SISTER Baltimore, Method of Disposition

| Date | Communication | Disposition | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | Dat 20a. Method of Disposition 20c. Location - City or Town, State ALEX., VA. M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, en disease or condition resulting in death) Medical Due to (or as a consequency of) Examiner Sequentially list conditions, cause. (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes No Month Day Year Pregnant at time of death 5 Other (specify) Yes 9 Unknown ot resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death by 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 124 hours after death.
Euneral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1♥ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury Natural 5 Pending Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Center 7+65

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH C912 2/25/2011 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:27 February 2011 ΔM RICHARD DAVID **JENKINS** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Frederick Frederick <u>Frederick Memorial Hospital</u> If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Mary Land 1 🛛 M 2 🗆 F Days Hours June 28 87 214-16-1690 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21710 5307 Doubs Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 9.43-1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 → Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Signal Maintainer Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lydia Pearl Joseph Jenkins 19a. Informant's Name/Relationship (Type, Print) 1979 on Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1373 Old Annapolis Road, Mt. Airy, Maryland 21771 Linda Stockman (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul's Lutheran 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 2/9/2011 Jefferson, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 106 East Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte Month Day Year Pregnant at time of death 5 Other (specify) 9 🗌 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Z Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 215/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 w 7th St Frederick imb Haiying 31. Date filed (Month, Day, Year) salstrar's Signature State Registrar

Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signatur

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JAN 201110:35 PM OTHO RADCLIFFE KING Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min OCT I 1941 1X M 2 🗆 MARYLAND Director 577-54-3012 69 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No PRINCE GEORGE'S **EDMONDSON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4815 51st AVE. 20784 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural", Specify: Completed 3 Widowed 4X Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) h and Mental Hygiene.
It is marked other than "r traumatic event, the Med during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 PLUMBER PLUMBING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK. permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev bef 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID FORTUNA/FRIEND 6907 VARNUM ST., LANDOVER HILLS, MD. 20784 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 1-31-2011 RIVERDALE, MD. . Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Cell Lymphoms Onset and Death arge Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a nonsequence off cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlat-fragal. Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autope, performed, 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: Certificate: To 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) and elle, my mu Cenny 18992000 25/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

32. Registrar's Signature

3001 HOSPITAL DR. CHEVERLY, MD. 20185

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leslie KAWIN 2011 9:10 A.M lanuary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 807 Hillsboro Dr. Montgomery 8. Date of Birth Apr. 19, 1925 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💢 F Germany Director 572-24-4155 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 United States 807 Hillsboro Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Food and Drug Elementary/Seconday (0-12) College (1-4 or 5+) Administration Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosa Wolf Fred David 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3850 Tunlaw Road, NW, Washington, DC 20007 Miriam Kawin, Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gardens 01/30/11 Olney, MD Törchfisky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line terval Between Immediate Cause (Final Onset and Death 3 Months Physician/ disease or condition resulting in death) <u>Dedifferentiated Liposarcoma</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Pregnant at time of death Day 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**)** No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 💢 No Other: ၉ 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Division of Vital Records, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified To the within 2 To the F

Box 68760

P.O.

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Michael Leibowitz.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.D

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c License number

11120 New Hampshire Ave., Silver Spring,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mildred Kaminsky Physician/ 20 Year January 22 5:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Rehab & Nursing Montgomery Olney If Under 1 Year Social Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours Min (Month, Day, Year 8-30-1920 1 🗆 M 2 💢 052-14-1647 90 Director Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant If item 27.5 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a ¹XX Yes 2 ☐ No MD Gaithersburg Montogomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 332 Little Quarry Rd 20878 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XXNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxxNo Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Jerry Irving Skulnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Kaminsky Vest - Daughter 332 Little Quarry Rd Gaithersburg 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ott 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hebron Cemetery 1/24/11 Flushing, Queens NY 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee 1091 Rockville Pike Rockville MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Coronary Artery Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attendir g physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death cert ficate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No as been signed by the 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypothyroid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas Dementia autopsy page performed? certificate 1 🗌 Yes 2 🗆 No Spinal Stenosis Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director. Be Hospital Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ XX Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1XXNatural injury work? 5 Pending after death. Director: Af 2 🗆 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pleted filled in by 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ☐ Medical examiner: On the basis of examination anglor investigation, in my opinion, opair occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1/22/11 D0057631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 10301 Georgia Avenue Silver Spring MD 20902

DHMH 17 Rev 7/2009

State Registrar

Anuradha Arun, 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
RegistriMFND#20erMD_2/1/11 • EMW_MCC

First Middle, Last) Certificate of Death Reg. No. 2. Date of Death 1 - 20 - 2011 1. Decedent's Name (First, Middle, Last) 3. Time of De. Time of Death January Physician/ D. Kahn Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death **Examiner Chevy Chase Montgomery 8100 Connecticut Avenue, Apt. 1507 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 X M 2 □ F Days Hours Min D9/1/27/P1/9/24 Germany 053-18-1274 86 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Montgomery Chevy Chase 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code Og. Citizen of What Country?
United States Funeral 20815 8100 Connecticut Avenue, #1507 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. "natural", Specify. 3 Nidowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Machinist permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Repair and Installation Proprieter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Strauss Sali Kahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Kahn/ Daughter 7421 Baltimore Avenue Takoma Park MD 209±2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🕅 Removal from State 01/23/2011 Westwood, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) Cedar Park Cemetery 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Signature of Funeral Solvice Licenses Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Year'S Immediate Cause (Final Physician, Coronary Athererosclerosis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Vec 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🔀 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and

31. Date filed (Month, Day, Year)

28

address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive

32. Registrar's Signature

1-21-2011

Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 12:35 P Allegra D. Lopes January 26. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** 96 Days Hours Min. Months Jan Watry 2 2 2 191 099-34-8388 Director Usual Residence of Decedent show 10b. County Montgomery 0a. State Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at ral", or items 23a or 28a-f shor Examiner must be notified at 10d. Inside City Limits Director 10c City Town or Location ng 1 Yes 2X No 10e. Street and Number 10f. Zip Code 20906 10g. Citizen of What Country? Completed by Funeral 3360 Gleneagles Drive, #1A 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Rattimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 → Widowed 4 □ Divorced White Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last)
Jacques Darsa 18. Mother's Name (First, Middle, Maiden Surname) 2 Esther Gratime 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19302 Pitciarn Lane, Huntington Beach, CA 92646 Charles Anthony Lopes / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Metropolitican Crematory 1 Burial 2 X Cremation 3 Removal from State January 2011 28 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. 40cas disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any leading to in mediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a sonseque To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Pregnant at time of death Unknown Month Dav Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has bal director, page 2 sl 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ဂ this 1 Npatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral (27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year,

State Registrar 18404

Oxfordshive Terrace Olucy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Paspu

Hruna

31. Date filed (Month, Day, Yea)

			For	tate of Maryland	d / De _l	oartment of H	lealth and M	Mental Hyg	giene			
			1 - State Registrar		C	ertificate of l	Death	T	Reg. No.2 () 1 1 5 8			
	Physici /Medic	cal	Decedent's Name (First, Middle, Last) Old O Aa. Eacllity Name of not institution, give stre	et and number		LAb City Town or	r Location of Death	2. Date of Dea Month	Day Year AM			
-	Examin Funeral	ier	5. Social Security Number 6. Sex	KINS ADSPIT		Baltin	If Under 24 Hrs. Hours Min.	h 9. Birl	hplace (State or Foreign			
	Director		587-69-0156 1□ M Usual Residence of Decedent	2 √ √ 53	Yrs.			June12,	1957 Chi			
Marylane a-f show		ctor	10a. State 10b. County Maryland Prince Geo		, Town or					10d. Inside City Limits 1 X Yes 2 No		
th with the 23a or 28 ust be no	23a or 26 ust be no	ral Directo	3422 Purdue Street			10f. Zip Code 2078	3		10g. Citizen of What Co United Sta			
U Z I Z I 3-UU 30 filed within 72 hours after death with the Maryland	Department of Heatin and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with inury or other traumatic event, the Marical Extra direct must be notified at once.	d by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2∑ No If Yes, Give Year or Dates:	S. 13	3. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🏋No	lispanic Origin? (Span, Mexican, Puerto Specify:	Black, White	14. Race - American Indian, Black, White, etc. Specify: Oriental			
- C1 :	n "natu	Completed	15. Decedent's Educati (Specify only highest grade co	empleted)	16a. De (Gi life	cedent's Usual Occup ve kind of work done o b. DO NOT use retired	ation during most of work d)	king	16b. Kind of Business/	Industry		
A 1A	ygiene ier thai t, in i	Com		College (1-4or 5±) 5+	Soft	ware Devel			Technology			
rar yrand 2 should be file	Mental H narked oth	To Be	17. Father's Name (First, Middle, Last) Shoufang Liu				18. Mother's Nam Yuxin G					
and 2 st	aith and 27 is n er traun		19a Informant's Name/Relationship (Type. Zhong Jun Wei -husb	er, City or Town, State, Zip Code) Naryland 20783								
t. Pages 1 a	ment of He tant: If item jury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)		ometery c	position (Name of rematory or other plac Itan Crema	tory1/29	Date /2011	20c. Location - City or Alexandria			
permit	Import any in		21. Signature of Funeral Service Licensee	orgen and					1 Home, PA	cyland 20705		
/N	ysician ledical aminer	. ·	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	on that caused the death ause on each line.	Do not e			3.13.1		Approximate Interval Between Onset and Death		
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unsease or injury that initiated events resulting in death) Last c	Due to (or as a consequ	,							
icate be executed	physician and s the burial-tr.nsit											
or Attending Physician: The law requires that the death certific	the attending p	hysician/Medical	in the past 12 months?	If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	у		23d. Date of de Month	23d, Date of delivery Month Day Year				
quires that t	en signed by the auld be detached t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3									
The law re	this certificate has been s ral director, page 2 should	Completed						24a. Was autop perfo 1 Yes	osy prior to death?	utopsy findings available completion of cause of		
vil.	s certif lirector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	pital: 1 ☐ Impatient 2 ☐ I	EB/Outpat	ient 3 🗆 DOA Otho	26. Place of Dea		<i>ne)</i> dence 6 □Other (Spe	noify)		
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or Attend	Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm,	M 1 ☐ Yes 2 ☐ No arm, street, factory, office 28f. Lo			Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital	To the Funeral Director: A completely filled in by the fu	Medical Ce		an: To the best of my know : On the basis of examinat and manner stated.								
To the	To the	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon			
y (۵.		30. Name and address of person who comp	leted cause of death (Item		e, Print)	N. Wolfi	151.	BALTIMOR	23, 2011 E,MD 21287		

State Registrar 31. Date filed (Month, Day, Year)

ith, Day, Year) 32 Hegis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month Leuna Jan. 27 2:57 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Kensington Park Retirement Community Kensington If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Aug. 15, 1 🛛 M 2 🗆 F Hours China 82 Yrs Director 1928 579-76-7068 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 ☐ Yes 2 🛂 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? **USA** Examiner must be Funeral with 23a 20817 8909 Hempstead Avenue items ; 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc P þ 1 Never Married 2 Married Yes Maryland 21215-0036 2 😾 No If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Asian "natural", Completed ¾™ Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ San Tang Mo-Yuen Leung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8909 Hempstead Avenue, Bethesda, MD 20817 Vincent M. Leung/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gate of Heaven Cemetery Cemetery 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 31, ^{Jan}11 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service L censes Name and Address of Facility
Encis J. Collins Funeral Home Inc.
University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Examine cause. Enter Underlying burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performe death? ☐ Yes 2 No 2 🗌 No the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other 1 \square Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Accident work? 2 🗌 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examiner on and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Certifying Nurse Practice eryTo the best of my house 3 only one att occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who compl death (Item 23a) (Type Print) cause 751 Rockville Pike, Hon-Yuen Wong, Rockville, MD 20852 31. Date filed (Month, Day, Year). 32. Registrar's Signature State MAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 27°, 201 Ta Leslie Harold LEVINSON 1:58 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3310 N. Leisure World Blvd., #620 Silver Spring Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 🗆 Days oct. 17, Year 1929 114-26-6856 81 Engliand **Director** Usual Residence of Decedent Fshov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3310 N. Leisure World Blvd., #620 20906 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or i iury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 🕅 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ College Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Levinson Ada Bloomberg 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
- 5th Street, SE, Washington, DC 20003 Lara Levinson, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot once. Date KKSI Cemetery or other place) 1 XBurial 2 Cremation 3 X Removal from State 01/30/2011 Nashville, TN 4 ☐ Donation 5 ☐ Other (Specify) e license Forchinsky Mebirew Funeral Home 254 Carroll St.. NW. Washington. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ <u>Parkinson's Disease</u> Years Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 Yes 2 No Yes 2 X No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🕅 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer. 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragrioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and fitte of certifier 29d. Date signed (Month, Day, Year) D 08381 January 27, 2011 erson why completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

18111 Prince Philip Dr., #209, Olney, MD

Awrunin,

M.D.

32 Registrar's Signature

Benjamin

31. Date filed (Month, Oaly, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrameno#28e, 28fperIME, 1/28/11. PMJ MCC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lawhorne Langworthy January 22, 2011 2:50P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Prince Georges Hospital Center Cheverly Prince George's 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours 229-24-6822 85 FEB#21, 1925 Director Vfrginia Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Jennii: Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Silver Spring Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3114 Gracefield Road, #112 20904 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ð Specify: White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced If Yes, Give Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Officer N.S.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Massie Lawhorne Marjorie Chewning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 Gracefield Road, #112 Silver Spring, MD James B. Langworthy -husband 20904 injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 1/26/2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician mtusions disease or condition rebrou Medical resulting in death) Due to (or as a consequence of) Examiner Security of the second of the Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death ed by the a detached f Unknown 9 Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 1 L Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 600 1 Natural 5 Pending herbed 1 Yes 2 No hin 24 hours after death the Funeral Director: Investigation Suicide 6 Could not be 28f. Location (Street and Manbator Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined nursing home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 10 55770 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mab 31. Date filed (Month, Day, Year) State 28

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** anuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 214-34-1058 73 March 23,1937 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 □ No Director the Medical Examiner must be notified Maryland Washington Boonsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ö items 23a 204 Young Avenue Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married ō Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify <u>\$</u> 3 Widowed 4 Divorced Specify: White 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Correctional Officer State of Maryland permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If iten 27 is marked other th any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer C. Long, Sr. Lillian Elizabeth Seipler ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona M. Long / wife 204_Young Avenue Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-04-2011 | Boonsboro, Maryland Boonsboro Cemetery 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 21. Signature of Funeral Service 7606 Old National Pike Boonsboro, MD 23a. Part 1 Enter the disease, or composhook, or heart failure. List only is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death use on each/i Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (ai or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician ard for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Tectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccq use contribute to the cause of death? by Ñο 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope has 1 Tes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one, Be examiner? Hospital: Other: 1 🗌 Yes 2 1 npatient 2 ER/Outpatient 3 🗌 DOA 4 \square Nursing Home 6 Cother (Specify) ဂ္ 5 Residence this 27. Manner of Death 28a. Date of injury Time of 28c. Injury at Work? 28b. 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 TYes 2 No I Director; A Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated the 29b. Signature and

Registrar DHMH 17 Rev 1/2001

State

30. Name and address

31. Date filed (Month, Day, Year,

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of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 26 State of Maryland / Department of Health and Mental Hygiene State Registral WCHD/SH 2/1/2011 per Dr. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year _Month Willis 1040 am Eugene Leggett Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Jan 26, 1 🕅 M 2 🗆 F Mary Land Director 219-12-0310 88 Ĭ923 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20816 Netz Road 21713 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decede... Armed Forces? → ☐ Yes 2 🗓 No traumatic event, the Me ical Examiner Black, White, etc. 1 Never Married 2 Married ō 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Furniture Manufacture Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Hem 27 Is marked any injury or other traumatic encores. ည Clarence Albert Leggett, Sr. Sallie E. Swope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey L. Leggett / Son 20019 Lappans Road Boonsboro, Maryland 21713 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Boonsboro Cemetery 01-31-2011 Boonsboro, Maryland 21. Signature of Funeral Sen 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 r the disease, or complication heart failure. List only one caus that viused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on victoria. 23a. Part 1. En shock, Approximate Immediate vause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of g physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death the 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe certificate 2 🗌 No Yes 2 1 Tes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 🗌 Yes 1 Inpatient atient 3 X DOA 4 Nursing Home -5 Re 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1/2 Natural (Month, Day, Year) 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 28, 2011 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ISQ HIGGINBOTHAM

State Registrar RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 11:45 am Ruth F. Mou January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Renaissance Gardens - Riderwood Prince George's Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Hours Min (Manth, 1Day, Year) 20 Director 577-64-7221 90 China Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Beltsville 1 Yes 2 X No Maruland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11945 Beltsville Drive 20705 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🗓 No Specify: "natural", 3 X Widowed 4 Divorced Specify Year or Dates. Asian Default. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Laundry Service 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tai Boon Leung Sue King Mou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Moy - Daughter 11945 Beltsville Drive, Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem: 02/03/2011 Adelphi, Maryland 21. Signature of Funeral Service Licensee.

Anneware 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. <u>11800 New Hampshire Ave., Silver Spring, MD20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer nset and Death

MUNUTES Immediate Cause (Final -Physician/ disease or condition resulting in death) Acute Cerebrovascular Accident Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death 5 Other (specify) Month Year 4 ☐ Pregnant 9 ☐ Unknown signed by the a 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

• Funeral Director: After this certificate has t leted filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work' Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicates: 1. the best of my king window death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature ap 29c. License number 29d. Date signed (Month, Day, Year) D24093 January 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 LaRene Maru McAlister January 1:20pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montaomeru Social Security Numbe 8. Date of Birth (Month, Day, Year) March 03, 1930 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours Director 80 Ohio 577-40-3333 Usual Residence of Deceden 28a-f show 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Maruland Montgomery Silver Spring 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 3641 S. Leisure World Blvd. 20906 U.S.A. death v 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Specify White Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Deptinit. Page 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William A. Rahn LaFern Hornickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Robert McAlister-Spouse 3641 S. Leisure World Blvd. Silver Spring. MD20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 02/03/2011 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Katrin 749 uson 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 Years Immediate Cause (Final Ph sician/ Cancer of the Vulva with Metastases disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to transdate cause. Enter Underlying Due to (or sels nonesquenes or) burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 🔀 No ate has been signed by the appare 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No After this certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury after death. Director: Af 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated hin 2 29b. Signature and title of certifier 10 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

6001 Muncaster Mill Road, Rockville, Maryland 20855

M.D.,

32 Registrar's Signature

Geoffrey Coleman,

3

31. Date filed (Month, Day, Year)

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2 1185	Physicia Medio		1. Decedent's Name (First, Middle, I	Malek							3. Time of Death 2212 M				
221	Examin		4a. Facility Name (if not institution, g Shady Grove						r Location of Death				Death gomery		
=	Funeral Director		5. Social Security Number 578 – 54 – 1182	If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B 8 / 2n0, /	irth 4 /, 19 =4 /	9. Birthplace (State or Foreign Padestine						
107	/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Montgomery Rockville										10	Od. Inside City Limits	
42	the Many or 28a-	Funeral Director	10e. Street and Number					ip Code			Citizen of Wha	it Count	1 Yes 2 No		
ARY	ath with ems 23a rmust t	unera	9701 Medical Center Drive 20850 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-										A i		
MALEK JANUARY	permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Inmoortant: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🎛 No Specify:					Specify:			American Indian, White, etc. White		
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OLGA	Page 1 tment of tant: If it jury or o		1 K Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	moval from State		cemetery, crem	na <u>t</u> ory or	other place	n 1/31	/2011			-	Spring, Md	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State amend#8, 17, 18. perfhdaughter 0 certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 Physician/ Month Year 12:05PM Januar BATOOL RAFII MOTLAGH 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death POTOMAC MANOR CARE POTOMAC Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min Director Tehran, 241-67-3204 Iran Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1x Yes 2 ☐ No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7012 Bradley Blvd. 20817 Iranian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housewife Private Be 17. Father's Name (First, Middle, Last) 18. MGQHARme (First, Middle, Maiden Surname) ည Mohammad Bagher Meschi Cohartai Meschi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shahla Abdel Malak / Daughter 7012 Bradley Blvd. Bethesda <u>Maryland 20817</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of F Important: If ite cemetery, crematory or other place! ò 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State any injury 4 Donation 5 Other (Specify) 1/24/2011 Beheshte Zahra Tehran, Iran 21. Si natura Funeral Service Licens 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ advanced disease or condition resulting in death) Medical Due to (or as a consequence of): GATIVE Examiner Failure Sequentially list conditions, if cause. Enter Underlying Cause (Disease or iinjury Examine (or as a nunsequence of): evere the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown ģ sate has been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Tes 2 🛛 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗷 No director. Be 26. Place of Death (Check only one) Hospital Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Dire

completed filled in b Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 00057458 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Pinky Sandeep Singh

31. Date filed (Month, Day, Year)
JAN 1 8 2011

32. Registrar's Signature

10714 Potomac Tennis Lane Potomac, Maryland 20854

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOODL Month 2256 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hnna Inne **Funeral** , Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) 1 M 2 - F Months Hours (Month, Day, Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No irginia 04150 Bumpass 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23024 unifed States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Black the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Marri Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) D. Moody nwie, md, 20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Important: I any injury o Moody Family Cemeter WAN. 15, 2011 4 Donation 5 Other (Specify) Bumpass 21. Signature of Funeral Service Licensee 22. Name ar Address of Farlity Ganesis Cremation and Funerals MO126 5732 Georgia NW. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner signed by the attending physician and de detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ≥ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed **Director:** After this certificate I 1 Yes 2 No 1 Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yeş 2. No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a, Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifia Name and address of person who completed cause of death (Item 23a) (Type, Print), DETENSE 441

DHMH 17 Rev 7/2009

State

Registrar

JAN 1 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2:29 GM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. Counfy of Death HOSP heverly G EOR Age (In yrs. last birthday)
Yrs. Social Security Number If Under 1 Year If Under 8. Date of Birth (Month, Day, 3 25 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director A 1 🗆 Yes 2 🗷 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 380 Jeaver SH 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. BLACK 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Lagt) ျှ 19a, Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, le 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initiary that initiated example. Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) by the g
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas performed autopsy 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 2 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending M ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical Eartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature 29d. Date signed (Month, Day, Year

State Registrar

DHMH 17 Rev 7/2009

JAN 18

2011

Physicial

300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

70077

Ricardo Minger 11-00216 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea Registrar 1. Decedent's Name (First, Middle,Lest) 2. Date of Death Physician/ 3. Time of Death Month Day January 7, 2011 2235 hrs Medical Examiner RICARDO VONDELL MINGER 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince Georges Hospital Center Cheverly Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) **Funeral** ForeignWashington Months Days Hours Director 1 X M Country) 2 F 577-25-0743 2/9/1993 DC Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 XYes 2 No 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f shot
injury or other traumatic event, the Medical Examiner must be notified at once, DC Director Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4020 1st Street SE #A301 20032 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2K No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: Black é 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student P.G. County Schools 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) BB Venlonte Vanshon Bethea Sylvia Ann Minger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4020 1st Street SE #A301 Washington, DC 20032 Sylvia Minger / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 1/15/2011 Donation 5 Other Specify Harmony Memorial Landover, Maryland 22. Name and Address of FacilityPope Funeral Homes, P.A. Signature of Funeral Service Licensee 5538 Marlboro Pike Forestville, Maryland 20747 art. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit ician/Medical AMENDED certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial -UNPENDED The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Physi 9 Unknown Division of Vital Records, P.O. Part ii. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other this ျှ 1 Yes After 27. Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 Natural To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: A **FOUND** 1 Yes 2 V No 5 Pending Director: Jan 7, 2011 2150 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 5330 E Street SE, Washington, DC determined (Specify) apartment 4 V Homicide 29a. Certifier 1 cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

January 8, 2011

State

29c. License numbe

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPHINE MACK JANUARY 10. 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 500 N. HARRY S. TRUMAN DR PRINCE GEORGE LARGO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2X□ F Months Days Hours Min. Director 262-32-6818 88 GEORGÍA Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD PRINCE GEORGE ARGO 28a-f 1 X Yes 2 No. 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 500 N. HARRY S. TRUMAN DR 20774 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ö 1 Never Married 2 Married 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene, marked other than Elementary/Seconday (0-12) College (1-4 or 5+) be filed within 12th SEAMSTRESS PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RAYMOND JOHNSON ARLALA BOONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 ROBERT E. MACK/SON Page 1 and 2 500 N. HARRY S. TRUMAN DR LARGO, MD 20774 or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN CEMETERY 1-17-2011 SUITLAND, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIO INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 X No Day Year Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à al or Attending Physician: The law requires after death.

I Director: After this certificate has been sign d in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 x No 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 😾 Residence 6 🗆 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 124 hours a' Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 [] 3 [] Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

yes

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

JAN 1 8 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN LILLY, MD 5804 BALTIMORE AVE HYATTSVILLE, MD 20781

D09357

29d. Date signed (Month, Day, Year)

1-11-2011

			-								All Copie Mental Hy		_	ible.			
	•	1 - State Registrar			.a. y .a.	•	rtificat					Reg. N	1.	1 1	01.170		
Physicia		1. Decedent's Name (First, Middle, Last) Frances Isobel MONGAN J.									2. Date of De Januar	ath	lama Aut	1 ^Y far	3. Time of Death 6:05p M		
Medic Examin		4a. Facility Name (if not institution, give street and number) 7 West Green Street						nksto	Location Dwn	of Death			c. County Washi	on .			
Funeral Director		5. Social Security Number 201–18–5114	6. Sex 1	2 🕱 F		last birthday) 86 Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Nov • 7	th y, Year)	924	g. Birthp Coun Penn	g. Birthplace (State or Foreign Country) Pennsylvania		
led within 72 hours a Hygiene. other than "natural" ent, the Medical Ex.	ctor	Usual Residence of Decedent 10a. State 10b. Cour Maryland Wash		ty, Town or Lo					1	0d. Inside City Limits 1 X Yes 2 □ No							
	ral Dire	10e. Street and Number 7 West Green Street P.O. Box 53 10f. Zip Code 21734									_	Citizen of W					
	by	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Divorce	S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc) 1 Yes 2 No Specify:							ean Indian, etc. white						
	Completed	15. Dece (Specify only hi Elementary/Seconday (0-12	(Give life. D	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)													
	To Be (12 0 nutrition aide governm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname))	<u> </u>				
		Dwight Beatty 19a. Informant's Name/Relationship (Type, Print) Gail A. Mongan - husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Post Office Box 53, 7 W. Green St., Fu											tate, Zip C				
		20a. Method of Disposition 1 Burial 2 Cremati 4 Donation 5 Othe	on 3 🗆 Rem		e (Place of Disponentery, creatinkstov	osition (Na matory or	me of other place	e)		Date uary 5,	20c. I	Location -	City or To			
permit. Departi Import any inj		21. Signature Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 217															
Physician/ / Medical Examiner		shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ininjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):															
cate be ey physician the buria	edical																
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of Month 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										ery Day Year					
uires that to n signed by uld be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to															
sician: The law req certificate has bee lirector, page 2 shoo	Completed									<u></u>		psy ormed?_	_ d	rior to cor eath?	osy findings available mpletion of cause of		
ian: T	Be C	25. Was case referred to medic	al					26. Place of Death (Check only one,					☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No one)				
nysici nis ce direc	2	examiner? 1 Yes 2 No	Hospi	ital: 1 🗌 Inpat	tient 2 🗌	ER/Outpatie	nt 3 🗆 D	OA Othe	er: 4 🗆 Ne	ursing Ho	me 5 Resid)					
ath. r: After thi	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injury						28c. Injury work: 1 🗆			28d. Describe h	8d. Describe how injury occurred					
rtal or Att ins after di al Directo led in by t		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)						
the Hospi nin 24 hou the Funer	Medical	(Check 2 Medica only one) 3 Certify	I Examiner: (ng Nurse Pra	n the basis of e	examinatio	n and/or inves	tigation, in	my opinio	n, death o	ccurred at	d due to the ca the time, date a e, and due to th	and plac	e, and due	to the cau	use(s) and manner stated		
To To to to	29b. Signature and title of certifier Mulhael Mulaurale Mo									29d. Date signed (Month, Day,				Oay, Year)			
10		30. Name and address of person	n who comple		death (Item	n 23a) (Type, F	Print)	redi	c = 1		Empus	·	Her	ersti	in MP.		
Stat Registra		31. Date filed (Month, Day, Year JAN 3)	32. Registr		d.	back	1			,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Benedetta Rita Moler AM 201 Medical 4a. Facility Name (if not institution, give street and number) . City, Town, or Location of Death Hagerstown 4c. County of Death Washington **Examiner** Meritus Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ay 30, 1927 215-24-6311 1 □ M 2 🛣 F Months Days Hours Min. Maryland **Director** Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21742 20009 Rose Bank Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cusimano Mary Thomas Gugluizza permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13514 Paradise Church Road, Hagerstown, MD Kathy Griemsmann -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Place of Disposition (Value of cemetery, crematory or other place)
Hagerstown Crematory

February 1, 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ UPTURED disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** THEROCCI ECOT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ ENTEROCOLITIS, HYSTERISION MAGGILE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed GASTROINTESTINAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HEMOREHAGE RETROPERITURIEAL HEMATOMA 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work?
1 Yes 2 No injury s after death.

I Director: Aft d in by the fur 2 Accident 3 Suicide Investigation Could not be within 24 hours after de **To the Funeral Directo** completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

egistrar's Signatur

OITE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FARRAR MEIKRANTZ, JR Month JANUARY JOHN 12:23P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 **⊠** M 2 □ F 170-34-6568 67 Director March Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Middletown 1 Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 United States 7093 Brownstone Court death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 72 hours after Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Farrar Meikrantz, Sr. Doris Kingsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7093 Brownstone Ct., Middletown, MD 21769 Nancy Meikrantz / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State remetery, crematory or other place)
Resthaven
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify) Frederick, Maryland 4 Donation 21. Signature Pineral Servi. ^{22. Name and Address of Facility}
Resthaven Funeral Services, Skkot Cody P.A.
9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between st only one cause on each line. Onset and Death Physician no xiz Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any leading to immediate cause. Enter Underlying Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Other (specify) Day been signed by the should be detached Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Division of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Npatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2011 MDD 35 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hee Nam Frederick, MD 21701 31. Date filed (Mand Day Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

CASSING

11-00675 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Roy Andrew Mayers State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar
1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 24, 2011 **Medical Examiner** 2244 hrs Roy Α. Mayers 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 504 E. Ridgeville Blvd Carroll Mt Ain 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Hours Min Months Days Director March 10, 194 Country) Penna. 162-32-2127 1XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No 28a-f show Damascus Maryland Montgomery narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country? 20872 U.S.A. 10802 Sir Barton Circle Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes White Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o 1 Yes 2 No specify: If Yes, Give Year 4 Divorced Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Grocery Owner/Operator 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Α. Mayers Sarah F. Heffelfinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 19a. Informant's Name/Relationship (Type, Print) Rosalie J. Mayers - Wife 10802 Sir Barton Circle, Damascus, Maryland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) Sum. Of Virgin Mary ran. Orth. Cemetery 1 X Burial 2 Cremation 3 Removal from State ssum. Jan. 31, 2**0**11 Northampton. Pa. Ukran. 4 Donation 5 Other Specify 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Lice Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland 20872 Approximate Interval **Physician** Between Onset and Madie al Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) kuse: Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -■ UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Live birth Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown n signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been a director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical or Attending Physiciao: 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours aff er death.

To the Fuoeral Director: A completely filled in by the fur 1 V Natural Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

Medical

29b. Signature and title of certifie

Hany

Pamela E. Southall, MD

31. Date filed (Month, Day, Year) 20

30. Name and address of person who completed cause of death (Item 23a)

32 Registrar's Signatur Grecia

Assistant Medical Examiner

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 25, 2011

OCIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Year masser 6:10 AM)anuary 701 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** PRINCE LINTON CARE VIEW 9. Birthplace (State or Foreign Country) TRAN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Days 1 X M 2 □ F 78 Month Day, 120-36-1283 Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE UPPER MARLBORD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d Mental Hygiene. marked other than "natural", or items 23a Funeral 20772 10801 INDIAN HEAD TRAN 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTH CARE PHYSICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I em 27 is marked o FARKHANDEH MOASSER MAHMOUD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3074 RIVA ROAD RIVA M.D. 21140 19a. Informant's Name/Relationship (Type, Print) SON MOASSER permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State PARK 01 /30/2011 FALLS CHURCH VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER EASY T. WODBRIDGE 23a. Part 1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Stage Physician/ End Dementi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or, the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Decabitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 2 1 N Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Investigation within 24 hours after devantable.

To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063337 105 85 anuam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seay Snigh Avenue Baltrune, Md Dorothy 2835 8te 203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23,2011 Physician/ January 3:42A Larue D. Manson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Hours Min. Director ug. 14 434-40-1500 1928 T.A Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X Yes 2 No PG Capitol Heights MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 United States 901 Rollins Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 🗌 Yes 2 🙀 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H item 27 is marked of ည Odessa Amos Hamp H. Manson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 01 Rollins apitol Hei Department of Health a Important: If item 27 is any injury or other tra Avenue ants, Md Dr. Susie Long/daughter 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State verdale Park Crematory Riverdale, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of Chronic Obstructive Lung Disease 24a. Was an autopsy page death? 2 No 1 Yes Yes Hospital or Attending Physician: Be 25. Was case referred to medica funeral director. 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending injury s after death.

I Director: Aft din by the fur ☐ Accider☐ Suicide Accident Investigation To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State

31. Date filed (Month, Day,

Shady

15245

32. Registrar's Signature

M.D

Grove Rd. #130, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stanley Harris Marshall **Physician** 27 2011 January 10:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5578 Kings Mill Drive

5. Social Security Number 6. Sex, Salisbury WICOMICO Months Days Hours Min. Min. Month, Day, Year) Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) **Funeral** 83 Maryland 215.22-8460 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Experiment rust be notified at Somerset lylerton 1 ☐ Yes 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number should be filed within 72 hours after death with USA 21866 3027 Tylerton Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Q 45If Yes, Give Year or Dates: 1947 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Ins. Ma. once. Elementary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie B. John T. Marshal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Constance Marshall P.O. Box 206 - Tylerton, MD 21866 Pages 1 and 2 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Union Church Cemetery Jan. 50, 2011 | 1418-1011, 1711)
22. Name and Address of Facility Bradshaw & Sons Funeral Home 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - Cristield, MD 21817 Immediate Cause (Final Adenocarcinoma Physician 4041 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncoming Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Home of Cousing Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No of Euneral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. To the l within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 030690 28,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cerroll ST. 5-1.56000 MD Jones MARTIN MO 31. Date filed (Month, Day, Year) JAN 2 8 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Year Physician/ Month Feb. :45 BLANCHE ELVA MOUNT 4 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Street Hart Heritage Estate Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Pay 1 □ M 2 🛣 F Country) Months Days Hours Min 144-18-1599 Yrs Director Jersey Usual Residence of Decedent or 28a-f shov 10a State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Street 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 3955 Old Rocks Road 21154 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 0 Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Oliver Havens Lucinda Herbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21754 3955 Mary M. Amrein (Daughter) Old Rocks Rd. Street, Maryland 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) FeBate 8, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Carroll Cremation Hampstead, Maryland 2011 21. Signature of Funeral Service Licen 22. Name and Address of Facility E.G. Kurtz & Son Funeral den Home Jarrettsville. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 L signed by the aid be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) : After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending death. To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 3588 7,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pHAN RelaiNAD 21014

Registrar DHMH 17 Rev 7/2009

State

Baltimore. Maryland 21215-0036

Box 68760

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Records,

Division of Vital

Date filed (Month, Day; Year)

DUGATION

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hannah Reba Nathanson 9 10:35 A M Medical January 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery **Examiner** 4b. City, Town, or Location of Death Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye May 2, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🖺 F North Carolina 89 Director 579-12-3819 1921 May Usual Residence of Decedent 23a or 28a-f show ust be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Silver Spring 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 1001 Spring Street #904 must United States death "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No
If Yes, Give or. Black, White, etc. within 72 hours after ò 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Ves 2 No Specify 3 Divorced 4 Divorced Completed Year or Dates I Hygiene. other than "natura ent, the Medical E White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant is marked other Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Fannie Smith Saul Nathanson and 2 should b Health and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidi Yacker / Cousin 5520 30th ST NW Washington DC other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Important: If it cemetery, crematory or other place, 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Falls Church, VA National Crematory 1/24/2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 23a. Part 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition Medica resulting in death) Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Metastatic Liver Disease - Unknown Primary Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2X No the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed Urinary Tract Infection 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Anemia of Chronic Disease After this certificate has autopsy performed Atrial Fibrillation 25. Was case referred to medical examiner?

1 ☐ Yes 2

X☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Investigation 1 Yes 2 No Accident 🔲 within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыетес Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu e and title of cer ē 29c. License number 29d. Date signed (Month, Day, Year) D0065009 01/09/2011 3. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sirak Lemma MD 1500 Forest Glen Road Silver Spring, MD 20910 30. Name and address of person who 31. Date filed (Month, Day, Year) ale State Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ January 20 Ruth Constance Needle 20T1 9:20p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8400 Harker Drive Potomac Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Months Days Hours Min June 19, 1919 Director 579-03-5071 91 Washington DC Usual Residence of Decedent 10a State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11430 Strand Drive #214 20852 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates. \$ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 🛪 o Specify: Specify: White 3xx Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Plumbing Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Klein Anne Sachs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abby Needle/Daughter 8400 Harker Drive Potomac MD 20856 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XXBurial 2 Cremation 3 Removal from State King David Mem Gardens 1/23/11 4 Donation 5 Other (Specify) Fairfax VA Signature of Funer Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Year shock, or heart failure. List only one cause on each line Metastatic Lung Cancer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 XXVes 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease has autopsy performed Yes XX certificate 1 Yes 2 No Hospital or Attending Physician: ⁻24 hours after death. Funeral Director: After this certifica upleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury work?
1 Yes 2 No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 29c. License number D45533 1/21/11

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Box 68760

Division of Vital Records,

Registrar's Signature

Dufief Mill Rd North Potomac, MD 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Snow, MD 15001

8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 20^{Yea} P^{M} 5:07 Tina May Ogan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Advestist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days Hours June 6, 1974 36 **Director** 453-93-8951 Texas Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD Montgomery 1 Yes 2 X No Montgomery Village 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò "natural", or items 23a o by Funeral and 2 should be filed within 72 hours after death with 9909 Forestview Place 20886 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: Caucasian 3 Widowed 4 Divorced Completed er than "natur , the Medical I May 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trave1 Travel Agent marked other natic event, th Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Sharon Cook IInk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9909 Forestview Place, Montgomery Village, MD 20886 Mr. Jamie Ogan, Spouse Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft.Lincoln Crematory 1/27/2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute MO1102 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final day ptic Physician/ Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial—ansit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1- Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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ames,

Registrar's Signature

9901 Medical Ctr Dr

Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LAVAUN PITTS-PROCTOR 7:24 pm ANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S HOSPITAL PRINCE GEORGE'S Social Security Number If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😾 F JULY 2 1948 WASHINGTON, DC 62 Director 577-66-7582 show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 35 LAUGHTON STREET 20774 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yes Invo If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ö þ 1 Never Married 2 XMarried permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Máryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGEMENT SPECIALIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY W. PITTS DORIS JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY C. PROCTOR/HUSBAND 35 LAUGHTON STREET UPPER MARLBORO, MARYLAND 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CEDAR HILL CEMETERY 1/17/2010 4 Donation 5 Other (Specify) SUITLAND, MARYLAND 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 21. S'an ature of Funeral Service Linensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မြ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif D63586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
Saifuctin Hussein, MD. 10756 Rhode Island Ave., Beitsville, MD. 20705 32. Registra 's Signat State

Registrar

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xamir		4a. Facility Name		n, give street and number	1)	4b. City, Town,	or Location ol Death		4c. County of Dea	ath Canpac
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mati	ပ္	19a. Informant's f		hip (Type, Print)	191	o. Mailing Address (Stree			ity or Town. State	Zip Code)
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To a		21. Signature of F	5 ☐ Other (Si				ress of Facility JB J			
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physician and dical strength and strength an	il Examiner	Immediate Cause disease or condit resulting in death Sequentially list of if any, leading to cause. Enter Unc Cause (Disease othat initiated even resulting in death)	conditions, immediate derlying or injury	c.	s a consequence	orj.	Mongh	m		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 31, Ronald Eugene Palmer, Sr. 2011 7:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15912 Falling Waters Road Williamsport Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F August 215-36-6757 Maryland Director 72 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15912 Falling Waters Road 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Aircraft Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Elwood Palmer, Sr. Kathryn Elizabeth Spigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Palmer - Wife 15912 Falling Waters Road Williamsport,MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burjal—2 💢 Cremation 3 ☐ Removal from State Hagerstown Crematory [Feb.5,2011 | Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of FacilityOsborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unide lying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 2 100 Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 OPAL 31. Date filed (Month, Day, Year) State FEB 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Clarence Milton Payne, Jr. January 9:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing Home Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) (Month, Day,) une 28 Months Days Hours Country) V<u>irginia</u> 1 M 2 D F Director 218-07-0430 91 Yrs. June Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3215 West Cedar Lane 20814 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Yes, Give 1944-1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: Specify 1946 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Army Map Service Cartographer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence M. Payne, Anna Laura Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health in tem 27 24815 Showbarn Circle, Damascus, MD 20872 Stephen M. Payne/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Upper Senica Cemetery Jan.28,2014 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Lightness 22. Name and Address of Facility Williams, P.A., Funeral Home Orjanley anul 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Aspiration Pneumonia Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **≟xamine**i Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Parkinsons Disease Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 2 🗆 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural (Month, Day, Year) 5 Pending 1 Tes 2 No М 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2011 D0035579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, 8218 Wisconsin Avenue, #305, Bethesda, MD 20814 MD. 31. Date filed (Mont) State

DHMH 17 Rev 7/2009

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Ö Division of Vital Records, within 24 hours after death

To the Funeral Director:
completely filled in by the

2 should be filed within 72 hours after and Nental Hygiene.

Maryland 21215-0036

CARDIOMYOPA

Baltimore,

State Registrar DHMH 17 Rev 1/2001

BAHRAM

31. Date filed (Month, Day, Year)

PISHDAD,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON, DC SE, 1328 SOUTHERN AVE.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:30am Betty Roth Januaru Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maple Ridge Assisted Rockville Montgomery Living Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Days 1 M 2 X F 1871 1920 90 Ohio Director 296-01-7464 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Rockville Maryland Montgomeru 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 15908 Maple Ridge Court 20853 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unobtainable) Sam Danziq Fannu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Jefferson Street, NW, Washington, DC 20011 1 and 2 s of Health Nancy Roth - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 01/30/2011 | Baltimore, Maryland 4 Donation 5 Other (Specify) Shaarei Tfiloh Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Whele |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Respiratory Failure) Medical resulting in death) Due to (or as a consequence of) Examiner Stroke Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated separately). Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Hypothyroidism 24a. Was an autopsy performed? death? certificate 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 1 ☐ Yes 2 🗓 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 X Natural 5 Pending work?
1 Yes 2 🔲 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D32332 January 28, 2011

Registrar

State

Box 68760

P.0.

of Vital

Division

9801 Georgia Avenue, #220, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signa

Suresh K. Gupta,

JAN 31

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:45am Samuel J. Raff Januaru Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8100 Connecticut Avenue. #1705 Chevy Chase Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 11/04/1920 1 X M 2 D F Months Days 90 Director 121-10-8384 New York Usual Residence of Decedent or 28a-f shov 10b. County filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Connecticut Avenue, 20815 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced Specify: WWII White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physicist Defense Department 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked ပ္ Nathan Raff Fannie Sagman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Hurley - Daughter 13 Quantum Place, Gaithersburg, Maryland 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date any injury or 2 Cremation 3 X Removal from State King David Mem. Grdns: 01/30/2011 | Falls Church, VA on 5 Other (Specify) 21. Signature of Furieral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the dilease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail rel List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or se a consequence of) attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Dementia with Lewy Bodies Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🔲 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2. only one) 29b. Signature and title of certifie D52258 January 28, 2011

Registrar
DHMH 17 Rev 7/2009

State

Gary B.

31. Date filed (Month, Day, Year)

Wilks

6430 Rockledge Drive, Bethesda, Maryland 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 334 Januar Patricia Ann REED Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center <u>Hagerstown</u> 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 1 □ M 2 💢 F 1966 Director 217-04-9478 44 May Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 331 Summit Avenue 21740 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. "natural", or i 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Cashier Retail Sales Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Deryl Ingold Virginia Clayton permit, Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumationce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Virginia Ingold - Mot</u>her Unit 101, Gaithersburg, Md. Lane, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 1/28/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home lex Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽hysician/ Nonsmal disease or condition resulting in death) Y-Pats Medical Due to (or as a consequence of) Examiner Massive Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Aspiration and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical po xia for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 2 No 9 Unknown Records, P.O. ò signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No Yes 1 🗌 Yes Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA this of 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending injury Division 1 Yes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director; completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D68995 nd address of person who completed cause of death (Item 23a) (Type, Print)

13 Eng, rap 1130 opal Ct Hagerstown, NAD 21740 Yong 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2011 Physician/ 4:10 AM MILTON URNER RANDOLPH January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial
Social Security Number 6. Sex Frederick Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F Days Hours Min. (Month Day, Year) Mary Land 213-18-8869 90 Director Aug Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21704 7712 Fingerboard Road 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 194
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. Black Completed by 2 □ No 1942 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3XXWidowed 4 ☐ Divorced 1945 Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) of Health Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Leo Randolph Mozelle Rollins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7712 Fingerboard Road, Frederick, Maryland Gwendolyn Graves - Daughter 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hopehill Cemetery 1-31-2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sign that of Funeral Service Licensee 21704 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Pnysician/ 1975 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No as been signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed' death? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🗷 after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 🗌 Yeş ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 🗌 Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Within 2 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) MD 20061410 2011 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 TOLL HOUSE HY, FRED 801 31. Date filed (Month, Day, 32, Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

num

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23, 20^{Year} 12:55 Рм ALBERT ROBINSON, JR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7009 Black's Mill Road Frederick Thurmont 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months July 4, 1926 Days Hours Maryland 220-18-1848 **Director** 84 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Completed by Funeral Director 1 Yes 2 X No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7009 Black's Mill Road 21788 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. WWII 3X Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter - Foreman Construction æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Albert Robinson Ruth Ellen Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhea Eckenrode / Daughter 7009 Black's Mill Road, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 1/27/2011 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens ROBERT E. DAILEY & SON FUNERAL HOMES, 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PO DIAL disease or condition resulting in death) hour **≱** Medical Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of s certificate has t lirector, page 2 s performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of After 1 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending after death.
Director: Aff 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my linewilledge, distilluo id at the time, date and place, and due to the nly one 29b. Signature daitle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause 104 MV 31. Date filed (Month, Da 32. Real trar's Signature State Green

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Margie E. Long Rathel **Physician** 10:30AM an. 9011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Somerset 28809 Larry Lankford Road rincess Anne Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 220-32-9080 1 □ M 2 X F Months Hours Delaware Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ **- any hiury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐Yes 2 No Somerset Princess Anne Maryland Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 28809 Larry Lankford Road USA 21853 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify <u>ک</u> 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Houltry Company Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Buliah Newcomb Hndrew ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5950 Harry Byrton Rd - Marian, MD 21838 Son Mike Long 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition rematory of Delmarva Jan. 28, 2011 Delmar, Demonstral Home 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cristield, mD 21817 Immediate Cause (Final a MALIGNANT CARCINOMA OF UNKNOWN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 000 2 🗆 X 🔾 1 □Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) . Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No neral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01482030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACISBULY D 6 HaleAn WARY 1300

State

Registrar

31. Date filed (Month, Day, Year)

JAN 28 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 845 M Marie ANUALTU ZOU orence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Rehabilitation and Nursing Center Montgomer Sandy If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth Country) NM **Funeral** April By Days 1 □ M 2 🖺 F Hours 525-46-2587 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Ashton Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20861 USA 17923 Pond Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11, Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", If Yes, Give Specify: ¾¥ Widowed 4 ☐ Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the once. 2 Nurse Be 18. Mother's Name (First, Middle, Maiden Surname)
Louise M. Schmitt 17. Father's Name (First, Middle, Last)

James J. Beilman ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17923 Pond Road, Ashton, MD 20861 Rita Suffness/Daughter 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Jan. 30 cemetery, crematory or other place) 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State 2011 Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. Spring, MD 500 University Blvd. W., Silver 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Zheime disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-flansit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes 4X Nursing Home 5 Residence 6 Other (Specify) ျ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Signature and title of certifier 29d. Date signed (Month, Day, Year) un attending who completed cause of death (Item 23a) (Type, Print) Crace Brooke Huffman M.D. 18100 Slade School Road Sandy Sp 31. Date filed (Month, Day, Year,

Registrar

Division or Vital Records, P.O. Box 68760,

State Registrar

se of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) 20

20850

30. Name and address of person who completed car

M.D., 1396 Piccard Drive, Rockville, MD Lauren E. Cosgrove,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ALLAN SHULMAN 5 / M JAN. 20 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** and Rehale Prince George's Patuxent River Healt Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Director 05/25/1928 207-20-3169 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐Yes 2 ☐ No Director Clarksville Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6817 Redberry Road 21029 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1945 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Completed by If Yes, Give Year or Dates: 1947 Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Department of Defense Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental tem 27 is marked o ٩ Nathan Shulman <u> Anna Goldberg</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Shulman/ Wife 6817 Redberry Rd. Clarksville MD 21029 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If It any injury or o ō 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns:01/23/2011 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852 adde Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myelocytic months disease or condition resulting in death) Acute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burnalest. Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Pheumonia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Mypertension 24a. Was an autopsy performed? Yes 2 2 No 2 **X**No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a

State Registrar (Check only one)

14300

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gallant Poxo

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Bowle

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

53411

Jogdish

29d. Date signed (Month, Day, Year)

2011

Jan. 2015

Shesadri

20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jamuary 25 2014ar 12:24 PM SEIDENBERG ALYCE MARIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours March Day 1 □ M 2 🏋 F 81 Year 1929 Pennsylvania 189-22-5096 Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ 10a, State with the Maryland Director Examiner must be notified Maryland Montgomery 1 Yes 2 No Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a 5110 Parklawn Terrace #302 20852 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked and violations or where any injury or where Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Amed Forces? 14, Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager C.V.S. Drug Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Sinclair Hamilton Martha Houck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26909 Howard Chapel Dr. Damascus, MD Bonnie Lynn Emery (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ukn. ⊠ Burial 2 □ Cremation 3 □ Removal from State Arlington Natl. Cém. Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility DeVol Funeral Home tes M01116 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arterioxles Otic coschovascules a Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? To the Hospital or Attending Physician: The law requires that the death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 0 Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No Division of VitaM 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Natural
☐ Accident
☐ Suic 5 Pending iniury Investigation Completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01/25/2011

State

Registrar

31. Date filed (Month, Day, Year)

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Registrar's Signature

11-00382

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Summer Scott 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ Month Day January 13, 2011 1154 hrs Medical Examiner Summer Scott 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Foreign Maryland Min. Months Hours 07/18/2009 Director 216-85-7337 1 2 F 1 M Usual Residence of Decedent 10d Inside City Limits iny 10a State 10c. City, Town or Location Baltimore 1 Yes 2 No MD Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6313 Monika Place #801 21207 USA Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? 2 X No Yes If Yes, Give Yeer or Dates: Yes 21 No specify: Specify: Black 3 Widowed Divorced 3 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roger Oliver Scott Kaisha Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ent of Health and Note: If item 27 is no other traumatic Roger Scott (Father) 6313 Monika Place, Baltimore, MD 21207 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State /20/2011 Dogation 5 Other Specify. King Memorial Park Baltimore, MD 5 22. Name and Address of Facility Phillip A. Weatherford, F.S. 21. Signature of Funeral Service License Oliver STreet, Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medica Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit ician/Medical tending physician suse as the burial -AMENDED UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 signed by the atte 1 Yes 2 V No 9 Unknown Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed of Vital Records. this certificate has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) Jan 13, 2011 28d. Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? Manner of Death Furniture items fell on top of subject 0926 hrs Division Natural 5 Pending 1 Yes 2 V No 2 🗸 Accident Investigation inby 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Direc 3 Suicide Could not be or Town, State) 6313 Monika Place, Baltimore, MD determined (Specify) Multi-Family Apt. Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 14, 2011 O.C.M.E. 4 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year, IAN 1 8 201 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend Item 20b State of Marylan	d / Depa	artment	of Hea	alth and	Mental Hy	giene	V // 1	
			RegistrarWCHD/SH 2/9/11 per FH 1. Decedent's Name (First, Middle, Last)	Cer	tificate	of Dea	ath	2. Date of De	Reg. No.		3. Time of Death
	Physicia			ndy				Month Januar	Dav	2011	11 A M
	Medic \ Examin		4a. Facility Name (if not institution, give street and number)	nay	4b. City, To	wn, or Loca	ation of Dea			County of Deat	
			20701 Violet Road		Roh	rers	ville		Washington		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 💢 F 7. Age (In yrs. Ia 1 □ M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	ast birthday) Yrs.	If Under 1 Months D		Under 24 Hr ours Mir		th 1938	Coa	thplace (State or Foreign untry) ryland
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	arylan a-f sh fied a	Director									10d. Inside City Limits 1 ☐ Yes 2 💢 No
	he Mis or 28a		Maryland Washington Ro	ohrersv	ville 10f. Zip Co	ode			10g. Citizen of What Country?		
	with t	Funeral	20701 Violet Road		2	21779				S.A.	,
	leath items ier m	Fun	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent	t of Hispan	nic Origin? (S	Specify Yes or No- rto Rican, etc.)		4. Race - Ame	
36	after o	d by	1 Never Married 2 X Married 1 Yes 2 X No		☐ Yes 2 🔀	_		ito i floari, ctc.)	Sa	Black, White pec <i>ify:</i> Whi	
8	nours latura ical E	lete	3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education	16a. Deced	lent's Usual C	Occupation	1			d of Business	
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Baltimore, Maryland 21215-0036	ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last) Charles Plunkert	ırname)							
Ž	ould k nd Me mark imatik		19a. Informant's Name/Relationship (Type, Print)	19h Mailin	n Address (S	treet and N		Oorothy M			Code)
Š	d 2 sh alth ar 27 is ertrau	- 8	Walter A. Sandy, Sr./Husband	1				hrersvil			· ·
ore,	of He fiterr	- 3	20a. Method of Disposition 20b. P	lace of Dispos	sition (Name o	of		Date		ation - City or	
<u>Ĕ</u>	. Page tment tant: I		4 □ Donation 5 □ Other (Specify) Sta	uffer	Cremat	tory		05-2011 35-2011			Maryland
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	V	21. Signature of Funeral Service Licentee	uneral ro, MD	Home, PA 21713						
			23a. Part 1. Enter the disease, or complications that aused the death shock or heart failure. List only one cade on each line.	n. Do not ente	r the mode o	f dying, su	ich as cardia	ac or respiratory a	rest,		Approximate Interval Between
	Physician/	8 6	Immediate Cause (Final disease or condition	T cu	DISEA	(DE				1	Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequ	ence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):							
	ate be executed ohysician and the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequ	lence of:							
0	be exi	edical E	Date to (or as a sorrough	dried dij.						-	
3760	ficate g phys		d								
x 687	ending	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Feta	ncy Il death 3 🗆	Ectopic pred	anancv			23	d. Date of del	livery
O. Box	ne death / the att	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of d 9 Unknown		Other (speci					Month	Day Year
9. 0.	requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions contributing to death but not resu	ulting in the ur	nderlying cau	ıse given in	n Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ds,	quires en sig ould b	ted	HYPOTHYPCIDISM					. 1 🗆	Yes 2	No 3 Pr	robably 4 Unknown
ecor	s ician : The law re certificate has be irector, page 2 shr	Completed	AWEMIA OF CHRONIC DIS	ease				24a. Was auto perfo	psy	prior to death?	topsy findings available completion of cause of
<u>~</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical			26. Place o	of Death (Ch	1 \(\sum \) Yes	ormed? 2 No	1 L Yes	2 No
Ĭ	nysici nis cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien	t 3 🗆 DOA	Other: 4	Nursing	Home 5 Resi	dence 6	Other (Spec	ify)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury		Injury at work?	2 🗌 No	28d. Describe	now injury o	ccurred	
VISIO	or Atter after des Sirector in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At how building, etc. (Specify)		et, factory, of	ffice		28f. Location (City or Tov		√umber or Rur	ral Route Number,
	Hospital 4 hours Cuneral I ed filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check 2 Medical Examiner: On the basis of examination	edge, death o	ccured at the	e time, date	e and place,	and due to the ca	use(s) and i	manner as sta	ated.
	thin 2, the F	Me	only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier		eath occurred		e, date and p		e cause(s) a	and manner as	stated.
	→ ≥ 5 8		The second secon	^		S88			Zad. Date s	signed (Month	
	15		30. Name and address of person who completed cause of death (Item	23a) (Type, Pr						31/201	
	7		STEVEN BLACK MD 12916 COVERNOR		te 204	f Ha	agerst	m nuo	0 2	1742	
	Stat Registra	_	31. Date filed (Month, Day, Year) FEB 0 2 2011	d.	ade		3	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 29, 2011 5:35 PM Carol LaPoint Sheldon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10818 Crystal Falls Drive Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
March 28,1923 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F New York Director 215-20-8192 87 Usual Residence of Decedent 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland 1 Yes 2X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10818 Crystal Falls Drive 21742 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White and Mental Hygiene. is marked other than "natural", 3 Divorced 4 Divorced Completed Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Albrecht Sheldon LaPoint Jessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 10818 Crystal Falls Drive, Hagerstown, Md. 21742 Suzanne Smith Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02-04-11 Rest Haven Cemetery Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

R. hoel Brade Arnorew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) obstructive pulmonary Chronic ears Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of physician and s the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending property for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) has been signed by the e 9 | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cerebrovascular disease 24a. Was an autopsy performed? director, page this certificate 1 Yes 2 No Yes 2 L 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dii 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 31,2011 Kuther Sand no D4745 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ashing to a County 747 North. Cynthia Kuther-Sands, my Hospics of Washing to a County, 747 North. 747 Northern Avenue

State Registrar Mary 1and 21742

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		State of I	Marylan	•	artment of F tificate of D		vientai Hy	giene Reg. N	2011	04201
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Examin		4a. Facility Name (if no 12464 A-			7)		4b. City, Town, or Keymar			40	c. County of Death Frede	
Funeral Director		5. Social Security Nun 214-46-592	25	ex ☐ M 2 🛛 F	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan • 4	th ay, Year 19	9. Birth Cour Mary	place (State or Foreign try) 1 and
yland -f show ed at	ctor		ecedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ※ No
th the Ma 3a or 28a t be notifi	al Director	Maryland				Keyma	10f. Zip Code			10g. C	litizen of What Cou	ntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	12464 A - 11. Marital Status 1 🖾 Never Married		12. Was Deceder Armed Forces 1 Yes 2	3?		Vas Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-		United 14. Race - Ameri Black, White,	can Indian, etc.
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nd 2 shou ealth and m 27 is n ner traum		Mary Fran	nces Sha			400 C				svi	lle, Mary	land 21793
Page 1 a ment of H ant: If ite ury or oth		20a. Method of Dispo 1 ፟፟፟፟፟፟ Surial 2 ☐ 4 ☐ Donation 5	Cremation 3	Removal from Sta	ate Ce	emetery, crer	esition <i>(Nam</i> e of matory or other plac et Cemete	ry 29,	Date uary 2011	Fre	Location - City or T	Maryl <u>a</u> nd
permit. Depart Import any inj		21. Signature of Fund	Service Licen	see to			Name and Address Fulton					es, P.A. and 21793
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The law require ate has been s page 2 should	Completed								24a. Was auto perfo	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
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anding Ph ath. r: After th re funeral	Certificate:	2 Accident	5 Pending Investigatio	n	njury Day, Year)	28b. Time of Injury	work	at at	28d. Describe			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		3 ∐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of I	Injury - At ho etc. (Specify)		eet, factory, office		28f. Location (City or Tou		nd Number or Rura e)	l Route Number,
the Hospi in 24 hou the Funer ipleted fill	Medical	(Check 2 only one) 3	Medical Exam Certifying Nur	iner: On the basis of	f examination	and/or inves	occured at the time, tigation, in my opinic death occurred at the	n, death occurred	at the time, date	and plac	e, and due to the ca	ause(s) and manner stated
To t Vith Con		29b. Signature and tit	le of certifier	c. W.	Q_x	CM	Dool	o 3 2 2 7			ate signed (Month,	
6		30. Name and addres	s of person who	completed cause o	f death (item	23a) (Type, F			•			

Registrar DHMH 17 Rev 7/2009

State

Virginia Willey 19 W. Frederick STREET Walkersville, MD. 21793

31. Date filed (Month, Pay, Year) 32. Registrar's Signature for the support of the support o

11-00604 Lana Elizabeth Sewell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	1- For State Registrar		Certific	ate of	Death			Reg.	No.		
Physician/	1. Decedent's Name (First, Midd	Mo							ay Year	3. Time of Death	
Medical Examiner	Lana Elizabet						Jan	uary 22,	2011	0555 1115	_
þ	4a. Facility Name (if not instituti Frederick Memorial F			4	b. City, Town, or L Frederick	ocation of L			4c. County of Frederick		
Funeral	5. Social Security Number	6. Sex 7	, Age (In yrs. last bir	rthday)	If Under 1 Year Months Days	If Under 2 Hours				Birthplace (State or Foreign	1
Director	219-46-3625	1 M 2 X F	63	Yrs.	Worth's Days	riours	N N	ov. 1	4, 1947	Foreign Country) Maryland	a
*	Usual Residence of Decedent 10a, State 10b, County		10c. City, Towr	or Logotic	200				_	10d. Inside City Limits	
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Balt permit. Depart Import injury	21. Signature of Funeral Service	Licensee	A 0							, MD 21716	
Physician	23a_Part I. Enter the disease, o	r complications that cal	sed the death. Do n	ot enter the	e mode of dying, s	such as card	diac or respir	atory arrest	, shock, or hear	rt Approximate Interva	
Medical	failure. List only one cause Immediate Cause (Final diseas	e on each line.								Between Onset and Death	i
Examiner	or condition resulting in death)	Due to (or as a c	onsequence of):								
	Sequentially list conditions,	b									_
miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence or):								
_ 2	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):								
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760, ficate be executing a physician and the burial - tra	IF FEMALE:		itcome of pregnancy		_				23d. Date of c	delivery	-
3876 rtificate ing phy as the	23b. Was decedent pregnant in past 12 months?	the 1 Live birt	h		al death 3	Ectopic pa	regnancy		Month	Day Year	
Box 68's death certification attending ad for use as hysician		denous		5 Oth	er (Specify)						
P.O. Box 68 inter the death certified properties as the attending detached for use as by Physician.	Part II. Other significant condi	9 Unknow		ng in the ur	nderlying cause gi	iven in Part	I. 2	3e. Did toba	cco use contrib	oute to the cause of death?	_
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. 1a Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	Hypertension				, , ,		I	1 Yes	2 No 3	Probably 4 Unknown	
ds, een sij							2	4a. Was an		Vere autopsy findings available	е
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tal Rections The certificate ector, page	25. Was case referred to medic	21			26 Place	of Death (C	heck only on	Yes 2	No1 [Yes 2 No	_
Vital hysician this certi I director	examiner?	-	patient 2 V ER/0	Outpatient		<u>`</u>	Nursing Hom		esidence 6	Other:	-
n of Vi	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury 28b.	Time of In	jury 28c Injur	y at Work?	28d. [escribe hov	w injury occurre	ed .	_
on cadin ath or: A the fur		nding	pay, rear)		1 Y	es 2 N	ło				
ViSi or Att her de birect in by t		estigation 28e. Place	of Injury - At home,	farm, street	t, factory, office bu	uilding, etc.		ocation (Street		r or Rural Route Number, City	,
Division o spital or Attending nours after death freezal Director: After a filled in by the fune Certification:	4 Homicide	ermined (Specify)						TOWII, Otal			3
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical E	(Oneth only	Physician: To the best aminer:On the basis of									
To the Hos within 24 h Tn the Fur completely		and manner sta		iiivestigati	29c. License		areu ar me n			ed (Month, Day, Year)	_
Ž į	29b. Signature and title of certif	lei	2.00		O.C.N			- 1	January 22,		
100	full		A do at 111 27		0.0.1				J ===,		_
0	30. Name and address of perso Russell Alexander M	· · · · · · · · · · · · · · · · · · ·	of death (Item 23a) edical Examine		V. Baltimore	Street, B	altimore.	MD 2122	23		
State			istrar's Signature		Kad		OCME				_
Registrar	. IRBI V C	2011 Ren	ma for	14000	CARSIA			OUME			
								COMME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:00 p. M Physician/ 2 1 ay Julia Starr Satterfield 201 Ta January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick **Examiner** Frederick Golden Living 8. Date of Birth
(Month, Day, Year)
6. 1917 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2424F Months Days Hours West Virginia 94 233-26-9907 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Trederick State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21702 USA 2100 A. Whittier Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or i 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify. "natural", Completed 3X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of Health and Mental Hyglene. Important if item 27 is marked other than "natur any injury or other traumatic event, the Medicall any injury or other traumatic event, the Medicall 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Loan Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ం Juliana Danchak John (Csillag) Starr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3822 Jefferson Pike, Jefferson, Maryland 21755 John Satterfield - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 ☐ Cremation 3 ☐ Removal from State Harpers Ferry, W. Virginia 1-28-2011 St. Peter's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service-Licensee 22. Name and Address of Facility Stauffer Funeral Home 2170 1621 Opossumtown PIke, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to inchediate cause. Enter Underlying Cause (Disease or linjury Duri to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): ysician a e burial-Physician/Medical nding physise as the l 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery atten for u in the past 12 months? Month Day Year signed by the a 9 Unknown P.O. Part Il-Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Records, 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? 1 Yes 2 No Yes the Hospital or Attending Physician: **Division of Vital** 25. Was case refe 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ithin 24 hours after death.

the Funeral Director; Aformpleted filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗗 🖴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who complete 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day 30 Year 2011 BERTHA SPAINE 2:05 PM MARY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COLUMBIA HOWARD COUNTY GENERAL HOSPITAL HOWARD COUNTY Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 XF Months Days Hours Min 9-6-1918 ear Director 92 185 09 0434 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 27 is marked other than "natural". 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 XNo MD Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13145 Triadelphia Mill Rd 21029 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed 3 XWidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Mielnizek Pauline Stucco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Spaine/Son 13145 Triadelphia Mill Rd Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Crematory 2-1-2011 Hanover, MD Signature of Funeral Service Licensee M01044 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Dnset and Death Physician/ disease or condition resulting in death) CORONARY ARTERY DISEASE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the attending physician a rector, page 2 should be detached for use as the bunials Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? is after death.

al Director: After this certification in hy the funeral director, pr 2 NO Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 . ER/Dutpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIRUDH CEDAR ANE COLUMBIA 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

FEB

32. Registrar's Signature

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	1. D	eceden

Certificate of Death trar

21853

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination to redified at any injury or other traumatic event, the Madical Examination to redified at angues.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name	e (First, Middle,	Last)					2. Date of D		Voor	3. Time of De	ath
1	JOH	N DAV	ID SWIFT	', J	R.			Januar Januar	y 26,	2011	4:00 A	M
r	4a. Facility Name (I	If not institution, g	give street and number)		4b. City, Town, o	r Location of Dea	th	4c. C	ounty of Death		
	Somerset	Garden	s Assisted	Livir	ng	Princes	s Anne		S	omerset		
	5. Social Security N				ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs		irth Day, Year)	9. Birthp	lace (State or F	oreign
	215-26-4	371	1⊠M 2□F	84	Yrs.	World Days	I I I I I I I I I I I I I I I I I I I	02/23/	1926	Mary	/ĺand	
	Usual Residence of 10a. State	Decedent 10b. County		10a City	, Town or Loc	otion				1	0d. Inside City L	imite
<u> </u>	Maryland	Somer	70+	Toc. City						'	1 ∐Yes 21	
			set		Princ	ess Anne				411111 1 0		
completed by Funeral Director	10e. Street and Nur 1.2360 Pal		hurch Road			10f. Zip Code	21853		10g. Citize	on of What Coun	itry?	
ela			12. Was Decedent	Cuprin II C	12 14			Specify Vac or N	0. 1/	1. Race - Americ	an Indian	
5	11. Marital Status	ied 2□ Marrie	Armed Forces')	8- III	as Decedent of H Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)		Black, White,		
ò	3 □XWidowed		If Yes, Give Year or Dates:	195	1 1	□Yes 2□XNo	Specify:		5	Specify: Whit	ce	
EG		15. Decedent's	Education		16a. Deced	ent's Usual Occup	ation		16b. Kind	d of Business/Inc	dustry	
be	(Special Elementary/Seco		grade completed) College (1-4or	5+1	(Give k life. D	rind of work done of NOT use retired	during most of wo d)	orking	Some	rset Cou	inty	
é	Shop Foreman Roads Dept.											
e l	17. Father's Name	(First, Middle, La	st)				18. Mother's Na	ime (First, Middle	e, Maiden S	urname)		
0	John D.	Swift					Leor	na Parki	nson			
	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mailing	g Address (Street	and Number or F	Rural Route Num	ber, City or	Town, State, Zip	Code)	
-	Annette	Humphrey	zs (Daughte	r)	3849	Kingsbur	y Drive					3
	20a. Method of Disp		☐ Removal from State	000	ace of Dispos metery, crem	ition (Name of atory or other plac	ce)	Date	20c. Loca	ation - City or To	wn, State	
		5 ☐ Other (Spe			yriðge M	lemorial Pa	rk 01/2	29/2011	Cri	sfield,	MD	
	21. Signature of uneral Service Licensee 22. Name and Address of Facility Bradshaw & Sons Funeral Home											
	Rober	t H. Br	ndshaw, Jr		30	6 W. Mai	n St C	risfiel	d, MD	21817_		
	23a. Part 1. Enter the disease, or complications that caused he deat. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
	Immediate Cause (Final disease or condition Onset and Death Onset and Death											
	resulting in death)	4	Due to (or as	a consequ								
	Sequentially list cor	nditions,	b									
	Sequentially list con liany, leading to cause. Enter Unde Cause (Disease or	rlying	Due to (or se	a consequ	ands of):							
Yall	that initiated events resulting in death) I	5	c Due to (or as	a consequ	ence of):							
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	IF FEMALE:		23c. If yes, outcome	e of pregnar	ncv				01	ad Data of delive	D.W. 4	
2	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pregnance Other (specify) _	у		23	3d. Date of delive Month	Day Yea	ar
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	Part II. Other signif	icant conditions	s contributing to death I	out not resul	Iting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to ti	ne cause of dear	th?
5								1	Yes 2	No 3□ Prot	oably 4 Unk	known
ונו								24a. Wa	san	24h Were auto	psy findings ava	ailahle
1	<u> </u>							- auto	opsy formed?	prior to co death?	mpletion of caus	se of
3	05 144							1 □ Yes	2 No		2 □ No	
2	25. Was case referrexaminer? 1 ☐ Yes 2 ☑		Hospital:		TD/O 4 - 1 - 1	3□ DOA Oth		eath (Check only			Assiste	2 d
	27. Manner of Deatl		28a. Date of Inj		ER/Outpatient 28b. Time of	28c. Injur	4 LI Nuising	Home 5 ☐ Res			y) Living	
5	1 ☑ Naturai 2 ☐ Accident	5 Pending investigat	(<i>Month, D</i> i	ay, Year)	Injury	Wor	ć? Yes 2 □No		, , , , , , , , , , , , , , , , , , , ,			
2	3 Suicide	6 ☐ Could not determine	be 28e. Place of In	jury - At hor	ne, farm, stre	et, factory, office		28f. Location	(Street and	Number or Rura	al Route Numbe	er,
ב ט	4 Homicide	Getermine	building, e	tc." (Specify)			City or To	own, State)			
2	29a. Certifier		Physician: To the best									
2	(Check only one)	2∐ Medical Ex	aminer: On the basis and manner s	of examinati tated.	ion and/or inv	estigation, in my o	ppinion, death occ	curred at the time	e, date and p	place, and due to	o the cause(s)	
Y I	29b. Signature and	title of certifier	/		-	29c. Licens	e number		29d. Date	signed (Month,	Day, Year)	_
) (2 grana	\ A	NA	100	0251	17	(226-	1/	
1	30. Name and address of person who out pleted cause of death (Item 23a) (Type, Print)											

State Registrar

31. Date filed (Month, Day, Year) JAN 2 7 2011

C. Stegman, M.D. - 30434 Mt. Vernon Road - Princess Anne, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan. $2^{D_{2}^{D_{2}y}}$ 2016:55 von der Lippe Maria Magdalena Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Montgomery Hospice-Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Aug. 3 1, 1923 Social Security Number 9. Birthplace (State or Foreign Country) Austria 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** □ **X** □ Months **Director** 218-38-7983 Yrs 87 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Silver Spring MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a USA er than "natural", or items 23 the Medical Examiner must 1086 Ruatan Street 20903 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. within 72 hours after δ 1 Never Married 2 Married 1 ☐ Yes : Specify: White 1 Yes 2 No Specify: 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ρ Josefine Wetzelsteiner Adolf Kranzelbinder Defermit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15601 Twin Valley Ct., Silver Spring, MD Jutta Bensimon/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/28/11 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Francis of Facility llins Funeral Home 500 University Blvd. W., Silver Spring, MI 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death **yrs** Physician/ Ischemic Cardiomyopathy Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 No Month 1 ☐ Yes 2X 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by as been signal page မ Medical Certificate:

Box 68760 P.O. Records, the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h Division of Vital the pleted filled in by

Maryland 21215-0036

Baltimore,

			1 Yes 2 No 3 Probably 4 1 Unknown
			24a. Was an autopsy performed? 1 ☐ Yes 23 No
25. Was case referred to medical examiner?		26. Place of Death (Check on	ly one)
1 ☐ Yes 2 X No	Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DC	Hospice 5 ☐ Residence 6 ★Other (Specify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day, Year) injury M	8c. Injury at work? 1 Yes 2 No	I. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	, office 28f	Location (Street and Number or Rural Route Number, City or Town, State)
	sician: To the best of my knowledge, death occured at ner: On the basis of examination and/or investigation, in r		ue to the cause(s) and manner as stated. e time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

D37142 1-23-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Coleman, MD

1355 Piccard Drive, Rockville, MD 20850

State Registrar only one)

31. Date filed (Month, Day, Year)

To the I within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2011 5:00 A VICENTE VALLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) pr 5, 1922 Cuba 1 X M 2 - F **Director** 218-66-8699 88 Apr Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick Adamstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2634 Inwood Drive 21710 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖪 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Cuban 1 X Yes 2 No Specify: If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Certified Public Accountant Financia1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Julian Valle Marguerita Llanes 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
325 Vixen Lane, Silver Spring, Maryland 20906 Ivette Martinez - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State -31-2011 cemetery, crematory or other place)

Gate of Heaven Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify entombment Silver Spring, Maryland Sig ture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): ∠xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 욘 1 A Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No after death Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a, Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 588 01/271 2011

State Registrar Florin

7th St

Frederick, md 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W

32. Registrar's Signature

ABLA-A

		For State	State	of Maryla		artment of I		d Mental H		21111	04208
		Registrar 1. Decedent's Name (First, Middle, L	ast)		Cer	uncate or i	Jean	2. Date of	Reg. I	No	3. Time of Death
Physicia		Robert J.	Whalen					Janua	rv 20	Day 2011 Year	7:45 A ^M
Medic Examin		4a. Facility Name (if not institution, gi		nber)		4b. City, Town, c	r Location of De			4c. County of Dea	
<u> </u>		5409 Golf Lane				North E				Montgo	mery
Funeral Director		215-12-1591	Sex 1 ☑ M 2 ☐ F		last birthday) 89 Yrs.	If Under 1 Year Months Days			Birth <i>Day</i> , 192	9. Bi	rthplace (State or Foreign ountry) Ohio
nd how at	٦c	Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation	_				10d. Inside City Limits
faryla 8a-f s tified	Funeral Director	Maryland Montgo	nerv		North	Bethesda					1 ☐ Yes 2 🛣 No
the Na or 2	I Dii	10e. Street and Number	J			10f. Zip Code			10g. 0	Citizen of What C	ountry?
n with	nera	5409 Golf Lane				208				S.A.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	A 1.5	2 □ No 19	42-	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🖾 No		(Specify Yes or I uerto Rican, etc.)	NO-	14. Race - Am Black, Whi Specify: W	
hours natur dical I	lete	15. Decedent's	Education		16a, Deced	lent's Usual Occup	pation		16b.	Kind of Business	Industry
nin 72 ne. than " e Mec	Completed	(Specify only highest Elementary/Seconday (0-12)	College (1			kind of work done O NOT use retired)		working		nmercial	
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be file ental I ked o c eve	P	William M. Whal						Name (First, Mide ce McCar		en Surnarrie)	
nould nd Me s mar		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street				or Town, State, Z	ip Code)
d 2 sładth a alth a n 27 ię		Teresa Whalen/	Daughter	c		Poplar R					
of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Demousel from		Place of Dispo		rel .	Date	20c.	Location - City o	
Page ment tant: I		4 Donation 5 Other (Spe				Heaven C	em. Ja	nuary ²⁷	, Si	lver Spr	ing, MD
permit Depart Import any inj		21. Signature of Funeral Service Lice	MO1	315		. Name and Addre					d 20877
Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on ea	caused the dea ach line. nanitic		er the mode of dyir	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death 6 Months
Medical Examiner		resulting in death)		or as a consecentia							2 Years
Ω _{si} α	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to	(or as a consec	quence of):						
xecute and and	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):						
ate be executed physician and the burial transit	dical		d								
tificat ng ph as th	Med	IF FEMALE:									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Towns Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial fransity.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Birth 2 Fe nant at time of	tal death 3	Ectopic pregnan Other (specify)	су		_	23d. Date of de Month	elivery Day Year
es that the signed by be deta	þ	Part II. Other significant conditions Spinal Stenosis	_	leath but not re	esulting in the u	nderlying cause gi	ven in Part I.				o the cause of death?
requir seen (etec	Essential Hyper	tension					24a, W			utopsy findings available
The law ate has l page 2 s	Completed	LSSencial hyper	Cension					— a	utopsy erformed? es 2 X	prior to death?	completion of cause of
cian: ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:				lace of Death (C				
Physic this c al dire	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗆		ER/Outpatier		4 L Nursin			6 ☐ Other (Spe	cify)
ding F h. After funer	Certificate:	1 X Natural 5 ☐ Pending		th, Day, Year)	injury	28c. Injur worl M 1	yat ⟨? Yes 2 □ No	28d. Descrit	e how inj	ury occurred	
Atten r dear ctor: by the	ŧ	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At h	nome, farm, stre	eet, factory, office	165 2 110	28f. Locatio	n (Street a	and Number or Ru	ural Route Number,
al Dire		4 El Homicido determino	buildi	ng, etc. (Speci	fy)			City or	Town, Sta	te)	
ne Hospit in 24 hour ne Funera pleted fille	Medical	29a. Certifier (Check only one) 3 Certifying Pt	miner: On the bas	sis of examinati	on and/or invest	igation, in my opini	on, death occurr	red at the time, da	te and pla	ce, and due to the	cause(s) and manner stated
NA INA		29b. Signature and title of certifier	15			29c. Licens D30				Date signed (Moni nuary 24	
'		30. Name and address of person who	completed caus Keegan,	se of death (Ite	m 23a) (Type, F riendsh	rint)	Suite '	T-90, Cl	nevy	Chase, N	⁄D 20815
Stat Registra		31. Date filed (Month, Day, Year)		egistrar's Sign	ature	Als					
		CARROLL CO.	A	- water of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra/MEND#23cperMD, 1/31/2011; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Weinstock dores 4:15 AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Q. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 472771933 New York 092-26-7454 Director 77 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15100 Interlachen Drive #325 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 24 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Completed ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the amy injury or other traumatic event, the lone. Book Keeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hyman Somerstein Lena Shopwesky 19a. Informant's Name/Balationship (Type, Print)
Larry Wienstock - son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6806 Moly Drive Falls Church, VA 22046 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memor I aler place)
Gardens 1/25/2011 Olney, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Edward 1 Rockville Pike Rockville MD 20852 M01163 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Sephic Shods disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respitrator Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attendion abusing and the attending physician and the for use as the burial-ransition Stag Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retai 40... 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, . Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24/2011 M. A. Mavanus 00071314 M.D

Registrar

DHMH 17 Rev 7/2009

State

18101 Prince Philip Drive Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

A. Mavanur M.D.

31. Date filed (Month, Day, Year)

JAN 2.8

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Name and address of person who completed cause

Theodore M. King, Jr., MD

2106

Assistant/Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

eath (Item 23a)

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

	mam	1- For State Registrar		artment of F rtificate of D		,,,	201	0421				
Physi Medical Exa		Decedent's Name (First, Middle,Last)	Michael E.	. William	s Sr	Date of De Month	ath Day Year	3. Time of Death 1220 hrs				
		4a. Facility Name (if not institution, give		4b.	City, Town, or Location	January of Death	4c. County of Deat					
Funera	al	2573 W. Lafayette Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. I		altimore Under 1 Year If Und	der 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Bir	thplace (State or				
Directo		220-64-9803 ₁ X			Months Days Hou		1 Foreign					
v any		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits				
Maryland 28a-f show	į	MD 10e. Street and Number			Baltimore			1 X Yes 2 No				
h the Mar	I Director	2573 W. Lafayet	te Avenue	10	f. Zip Code 21216		10g. Citizen of What Cou USA	ntry?				
r death wii	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No	If Yes,	specify Cuban, Mexica		o- 14. Race - Amer White, etc.	can Indian, Black,				
ırs afte	þ	3 Widowed 4 Divorced II 15. Decedent's Education (Specify only			sual Occupation (Give		Specify: B1a					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In important: If them 71 is marked other than "astural", or items 33a or 23a-f sho ling or other frammitic group the Medical Promises to enter the medical Promises.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most o	f working life. DO NO.	Tuse retired)	Privat					
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2121 Jid be f Mental marked	To Be	Mitchell William 19a. Informant's Name/Relationship (Type		19h Mailing Ad	Tess (Street and No	homasina Da	AVIS mber, City or Town, State					
MD 21215-0036 d 2 should be filed within 7 in and Mental Hygiene. In 27 is marked other than immit excet the Medical Medical Count.	-	Tamika Williams (I	•									
or Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	rematory or other p	iace)	Date	Baltimore M 20c. Location - City or	Town, State				
Baltimore, sernit. Pages I ar Department of Hes Important: Uter I free		4 Opnation 5 Other Specify:	MD		Cemetery	1/21/2011	Crownsvil	le, MD				
Bal perm Depa Impo		Tattices Tal	2431 E. Oliver Street, Baltimore MD 21									
Physiciar /Medica		23a. Part I. Enter the disease, or complic failure. List only one cause on each	ode of dying, such as o	cardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and						
	Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
		Sequentially list conditions, b. Bi	eakdown of dialysis sl	hunt								
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uted nd ransit	Exar	events resulting in death) Last Du d.	e to (or as a consequence of)):								
/60, cate be executed physician and he burial - transit	Wedical		AMENDED									
3876 rtificate ling phy as the	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn1 Live birth	ancy 2 Fetal de	ath 3 Ectopic	pregnancy	23d. Date of delivery Month D	ay Year				
Box 687(death certifica the attending pl of for use as the	Physician/	1 Vas 2 No d Ulakasura	4 Pregnant at time of dea 9 Unknown	ath 5 Other (Specify)							
Records, P.O. Box 68760, The law requires that the death certificate be executed coate has been signed by the attending physician and page 2.5 wild be detached for use as the burial - transi	Ð,	Part ii. Other significant conditions co	ontributing to death but not res	sulting in the under	ying cause given in Pa		obacco use contribute to the					
require	leted					24a. Was a	an 24b. Were auto	opsy findings available				
of Vital Records, ag Physician: The law requir ther this certificate has been s meral director, page 2 s wuld 1	Completed					autop perfor 1 Yes		mpletion of cause of				
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n of Vi ding Physi After this funeral dir	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	R/Outpatient 3 28b. Time of Injury	DOA Other 4 28c. Injury at Work		Residence 6 🗹 Other:	Scene				
	ation	1 Natural 5 Pending Investigation	(Month, Day Yeár) Jan 12, 2011	1210 hrs	1 Yes 2 ✔	Dialysis shu	nt broke down and	deceased bled				
Divis	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Homicide Could not be determined Specify) Rowhouse 255. Thire of Injury 255. Thire of											
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: /	edical	one) 2 Medical Examiner:Or an	To the best of my knowledge the basis of examination and d manner stated.	e, death occurred at d/or investigation, in	the time, date and pla my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated and place, and due to the	i. cause(s)				
	Σ	29b. Signature and title of certifier	K O(T)		O.C.M.E.	CME	29d. Date signed (Mont January 13, 2011	h, Day, Year)				
22		30. Name and address of person who com Theodore M. King, Jr., MD.	pleted cause of death (Item 2 Assistant Medical Ex	-	V. Baltimore Stre	eet Baltimore MD	21223					
		31. Date filed (Month, Day, Year)	32. Registrar Signatule		- Dalamore offe							
Regis	trar	JAN 1 8 2011 A	un p. 19									

		Please Type or Print in Black Indelible Ink.		_			
		State of Maryland / Department of He	-	giene,	11.212		
		Registrar Certificate Of D		Reg. No.	The Law I have		
Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year	3. Time of Death		
/Medica	al	Crawford Lonzo Winters		30 201			
Examine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L Hales	Stown of Death	4c. County of De	1		
Funeral	×	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8 Date of Birt	th 9 Bi	rthblace (State or Foreign		
Director		442-18-5250 12X M 2 F 89 Yrs. Months Days	Hours Min. May 12	, 1921 Ok.	Lahoma		
p »	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
laryla shov		Maryland Washington Hagerstown			1 Yes 2X No		
the N		10e, Street and Number 10f. Zip Code		10g. Citizen of What C	Country?		
with 3a or 1t be 1	٥	20001 Old Forge Road 2174	2	U.S.A.	,		
death ms 2: mus	Funeral		panic Orlgin? (Specify Yes or No , Mexican, Puerto Rican, etc.)				
after or itte	ᆵ	1 □ Never Married 2 1 1 Married 1 1 Married 1 1 Married 1 M	Specify:				
ours.	d by	Teal of Bales.		Specify:	white		
5-C	Completed	15. Decedent's Education 16a. Decedent's Usual Occupat (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired)	ion Iring most of working	16b. Kind of Busines	s/Industry		
withir ene.		Elementary/Secondary (0-12) College (1-4or 5+) 12 plant manage		pectin p	lant		
d 2 filed Hygi	ပ္		18. Mother's Name (First, Middle,		Tant		
lan lan lan lan lan lan lan lan lan lan	To Be	Rex Winters	Leora	Crawford			
ary shou s mark		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street ar	nd Number or Rural Route Numb	er, City or Town, State,	Zip Code)		
and 2 and 2 saith 3			ge Road, Hagers				
Ore jes 1 of He r iten		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State	February	20c. Location - City of	or Town, State		
tim Pag Iment Iant:		4 Donation 5 Other (Specify) Hagerstown Crematory 1, 2011 Hagerstown, Maryland					
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402.60	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying	lson Blvd., Hag		Approximate 21/40		
		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death		
Physician /// /Medical	er	disease or condition resulting in death) a. Cerebrovascular ACCI is	dent-Hemon	rchagic			
Examiner		Due to (or as a consequence of):		U			
The state of		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.					
O, exect an an rial-tr	EX	resulting in death) Last Due to (or as a consequence of):					
376 ate be nysick he bu	<u>ca</u>	d					
C 68 ertifica ting pt	Med	IF FEMALE:					
P.O. Box 68760, that the death certificate be executed and by the attending physician and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant 23c. If yes, outcome pt pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d Month	elivery Day Year		
O. In the dear the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)					
P.(문	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I. 23e. Did t	tobacco use contribute	to the cause of death?		

Year e cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1∐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires t within 24 hours after death.

Within 24 hours after death.

The Funeral Director: After this certificate has been signe by the Funeral director, page 2 should be

Division or Vital Records,

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

R118578

29d. Date signed (Month, Day, Year) 1-31-2011

who completed cause of death (Item 23a) (Type, Print)

14014 Marsh Pike Heyerstown MD 21742 32. Registrar's Signature

🛚 🗶 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

31. Date filed (Month, Day, Year) FEB 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 24 Physician/ 201^{Year} Charles Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2704 Jaybird Court Knoxville Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0ct. 5, 1960 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 1 🛛 M 2 🗆 F 215-80-4848 Director Maryland 50 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Frederick Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2704 Jaybird Court 21758 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. ģ 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Specify: White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Carman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Buck Weddle Catherine Weddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sk.
Department of Health al
Important: If item 27 is 2704 Jaybird Court, Knoxville, MD 21758 <u>Phyllis Weddle / Wife</u> injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2011 Stauffer Crematory Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21726 1. Enter the dise se or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Talle Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ending physician and use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: ¹ within 24 hours after death. To the Funeral Director: After this certific: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 200 မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1
Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Frederick, MD 21701 MD 501 W Elhamy Es Kander 32. Resistrar's Signature GARRA Registrar

Box 68760

P.O.

Records,

Division of Vital

11-00672

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

McKinney White,		State of Maryland / Department of I		_	201	0421
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last) McKinney Antonio White, Jr.		Date of Death Month January 24	Dav Year	3. Time of Death 1727 hrs
		5736 Silver Hill Road	. City, Town, or Location of Death Suitland		4c. County of Death Prince George	e's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577-06-3323 1 N 2 F 34 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min	-	1976 Society (MM/DD/YYYY) 9. Bir 1976 Co	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygene. tean 27 is marked other than "natural", or items 23s or 28s-f show any traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Prince George's District				10d. Inside City Limits 1 X Yes 2 No
	Il Director	10e. Street and Number 1881 Tanow Place	10f. Zip Code 20747		g. Citizen of What Cou	
	Be	1 Never Married 2 Married Armed Forces? If Yes 1 Yes 2 X No	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	can Indian, Black, a.c.k
36 nin 72 hours a itaa "natura dical Exami			Usual Occupation (Give kind of v t of working life. DO NOT use reti	red)	16b. Kind of Business/ Private	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) McKinney Antonio White, Sr.	18.Mother's Name Barbara	(First, Middle, Ma a Ann M	aiden Surname) anley	
	<u>۵</u>	19a. Informant's Name/Relationship (Type, Print) Barbara A. Coleman/Mother 1881 20a. Method of Disposition 20b. Place of Disposition		istrict		, MD 20747
			place) 1 Cemetery 0.1 -ne and Address of Facility	-29-201	1 Suitla	nd, MD 20746
യ ള്റ്ളിള Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ar Hill FH,42 mode of dying, such as cardiac o			Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): Sequentially list conditions,				Doday
git d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that infitiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
be execuician and	dical	d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Division of Vital Records, P.O. Box 68760 within 24 hours afterding Physician: The law requires that the death certificate by the Ruseral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregnar (Specify)	ncy		Day Year
		Part II. Other significant conditions contributing to death but not resulting in the unc	erlying cause given in Part I.		acco use contribute to	ably 4 Unknown
tal Record ian: The law rec certificate has bee				autopsy perform 1 V Yes 2	prior to death?	topsy findings available ompletion of cause of
Vital ysician his certi	S Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check of B DOA Other Nursin		esidence 6 🗸 Other	: Scene
Division of Vital Records, P.O. pptal or Attending Physician: The law requires that the ours after cleath. Beral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detended.	Certification: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 Natural 5 Pending FOUND: Day, Year) FOUND: TOURD IND 2 Accident Investigation Jan 24, 2011 1702 hrs	1 Yes 2 ✔ No	Subject shot	w injury occurred	
Divisio To the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the		3 Suicide 4 ✔ Homicide Could not be determined Could not be determined (Specify) Local Street		or Town, Sta	reet and Number or Ru ite) Road, Suitland, MD	
To the Howithin 24 h To the Fu	edica	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)				
6		highe: v.	O.C.M.E.		January 25, 2011	
A Sta		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Street, Baltimore, MD 21.	223		
Registr		FEB 0 1 2011 Server B. Jacks				
DHMH 17 Rev 1/200 OCME 2006	01	ORIGINAL		(DOME	

11-00576

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Thelma Young	State of Maryland / Departm 1- For State Registrar Certific	ent of Health and Mental F ate of Death	lygiene Reg. No.	2011 04215		
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death		
Medical Examiner	The Ima Virginia Young 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dear	January 20, 201	1 2334 hrs		
	18817 Crofton Road	Hagerstown		ashington		
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last bird.)			D/YYYY) 9. Birthplace (State or		
Director	217-28-7310 1 M 2 F 77	Yrs. Months Days Hours Mi	02/13/1933	Foreign Country Maryland		
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits		
*				1 Yes 2 No		
the Maryland a or 28a-f show tified at once. Director	Maryland Washington Hagers 10e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?		
the M	18817 Crofton Rd.	21742	IJ.	S.A.		
er death with t , or items 23a r must be not Funeral I	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No- 1	4. Race - American Indian, Black,		
or ite	1 Yes 2 No			White, etc.		
urs afte	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of		Specify: White nd of Business/Industry		
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re		nd of Business/industry		
vithin ene r tha Medic		Homemaker	D	Oomestic		
15-C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden S	Surname)		
2121 tould be fil d Mental H s marked tic event,	Charles Clingan 19a. Informant's Name/Relationship (Type, Print) 19l	Erma (b. Mailing Address (Street and Number or	GTOSS Rural Route Number City	or Town State Zin Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	M	2307 Old Pen Mar Rd				
re, l 1 and 1 and 1 Healt f item er tra	20a. Method of Disposition 20b. Place of	of Disposition (Name of cemetery, bry or other place)		ocation - City or Town, State		
Pages nent of ant: I		· · · · · · · · · · · · · · · · · · ·	/25/2011 Нас	erstown Maryland		
Salti ermit. Pepartn mport njury	21. Son ture of Funyral Service Licensee	22. Name and Address of Facility Res	st Haven Fun	eral Chapel		
Physician	23a. Party. Enter the disease, or complications that caused the death. Do no	11601 Pennsylvania	Ave. Hagers	town Maryland 21741		
/Medical	failure. List only one cause on each line.		or respiratory arrest, snoc	Between Onset and Death		
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Due to (or as a consequence of):	Cardiovascular Disease		00001		
	Sequentially list conditions, b					
ted I Insit Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c					
Exar	events resulting in death) Last Due to (or as a consequence of):					
Ecords, P.O. Box 68760, le law requires that the death certificate be executed the that been signed by the attending physician and ige 2 should be detached for use as the burial - transit ompleted by Physician/Medical Ex	d. UNPENDED AMENDED					
J. Box 68760, the death certificate be executed the attending physician and other for use as the burial - trapic Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d	Date of delivery		
Sox 6876 leath certificate e attending phy for use as the l	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn		Month Day Year		
Box e death of the attented for us	1 Yes 2 No 9 ✔ Unknown 9 Unknown	Other (Specify)				
that the d that the d detached by Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?		
s, P.O. ires that the signed by Je detack			1 Yes 2	No 3 Probably 4 ✔ Unknown		
ords, requir			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
Records, T e law requires ficete has been sig page 2 should be Completed		-	performed? 1 Yes 2 ✔ No	death? 1 Yes 2 No		
clan: certi ector	25. Was case referred to medical examiner? Hospital: 4 I postiont 2 EB/O	26.Place of Death (Check stpatient 3 DOA Other Nursi		-		
of Vi Physicer this eral dir	1 ✓ Yes 2 No	introperation interest in the	ng Home 5 Resident	ce 6 🗹 Other: Scene		
ion C tending eath. or: Af the fun	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	Zod. Dosonbe flow injury	y occurred		
Division tal or Attendin rs after death. al Director: A led in by the fi	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.		d Number or Rural Route Number, City		
Division of spital or Attending tours after death. neral Director: Aft filled in by the function of the functi	4 Homicide determined (Specify)	<u> </u>	or Town, State)			
Di To the Hospital within 24 hours a To the Funerall completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
To with Com	29b. Signature and title of certifier	29c. License number	·	ate signed (Month, Day, Year)		
	ampz	O.C.M.E.	Janu	ary 22, 2011		
	30. Name and address of person who completed cause of death (Item 23a)					
5H-1	Ana Rubio MD. Assistant Medical Examiner 900 W	/. Baltimore Street, Baltimore, M	D 21223			
State Registrar	31. Date filed (Month, Pay Year) 2011 32. Redistrar's Signature	back				
DHMH 17 Rev 1/2001	OR	GINAL	OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fern Year 5 21:06 PM 201 Medical Name (if not institution, give street and number) Examiner 4a. Facility 4b. City, Town, or Location of Death 4c. County of Death Spring Montgomery r055 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** In vrs. last birthday 1 □ M 2 🖾 F Hours Min. 6618 53 **Director** Yrs. Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland at Director 10c, City, Town or Location 10d. Inside City Limits notified 28a-f 1 🛚 Yes 2 🗆 No Jonita Prin 10e, Street and Number ò 10g. Citizen of What Country? ural", or items 23a o Examiner must be Funeral 902 Sal eedie vador 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Yes 2 🖼 No 1 x Yes 2 No Specify: Salvadorian If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed HISDANIC the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) House keepe own house of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ permit. Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked Hrevalo HUESO 0 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 20902 10 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 12011 4 Donation 5 Other (Specify) Juan Upico Funeral Services fre Signature of Funeral Service Licenses 22. Name and Address of Facility Santa any in Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to it r as a conse juence of the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 2 1 No Other: မြ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1
Natural 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signat and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 608

Registrar
DHMH 17 Rev 7/2009

State

30. Name

20910

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

urax

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Louis Appold F<u>ebruary</u> 2011 10:35P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3812 Perryhurst Place Nottingham Balto. 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Maryland **Director** Yrs 216-30-5181 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Balto. Nottingham 10e. Street and Number ò 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 3812 Perryhurst Place 21236 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th Manufacturing Maintenance Maintainer Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental Fishers is marked o permit Page 1 and 2 should be 1
Department of Health and Mental Important: If item 27 is more any injury or other once. 2 Edward Burke Anna Appold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Appold Spouse 3812 Perryhurst Place Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Dulaney Valley 2-15-2011 Timonium, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Squamous Cell cancer disease or condition resulting in death) Due to (or a a conservence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1

Yes 2

No 3

Probably 4

Unknown should semo peen 24a. Was an 24b. Were autopsy findings available this certificate has ral director, page 2 prior to completion of cause of death?

1 Yes 2 WNo autopsy performe Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ည 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death.

I Director: After to in by the funera Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sqrt{Yes} 2 \sqrt{No} 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) asallam M.D P45530 2-14-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILADELPHA ROAD, MD 21237

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

9/14

·SIVASMILAM, suche

31. Date filed (Month, Day, Year)

5

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AKhtar Physician/ Aamina Month Year 4:45 AM February 2011 Medical Facility Name (if not institution, give street and number) ounty of Death Examiner da . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 070-28-064 Director Usual Residence of Deceden "natural", or items 23a or 28a-f shov edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2908 1150 21215 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify 3 **M**Widowed 4 ☐ Divorced ack 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industr (Give kind of work done during most of working life. DO NOT use retired)

VI Servant/Para (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr arsella 20a. Method of Disposition Place of Disposition (Name of cometery, crematory or other Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-2011 Signature of Funeral Service Lice Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Atheroscherotic Cardiovascular Disease Onset and Death Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for all a nonsectionne off cause. Enter Underlying Exami To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transl Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h perform 2 No Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining rystation in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check MSRajapahse M.D 29c. License number DB057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapakst / M.D. 2635 5m) Th. M. 5 - 203 Baltimore, MD. 21209

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

· Rajapakse, M.O.

NS 3 M Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Andrew Mark Asher State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3. Time of Death Month Day February 9, 2011 **Medical Examiner** 1050 hrs Andrew Mark Asher 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2485 Red Fall Court Gambrills Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Min Director February 12,1964 1 X M Country) Maryland 219-90-4297 2 F 46 Usual Residence of Decedent in' 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County or 28a-f show 1 Yes 2 X No items 23a or 28a-f shoust be notified at once. Maryland Gambrills Anne Arundel Director 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 21054 United States 2485 Red Fall Court Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, nther than "natural", or items the Medical Examiner must be. 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No If Yes, Give Year or Dates: 3 Widowed 4 X Divorced 1 Yes 2 X No specify: Specify: White <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 i. Pages 1 and 2 should be filed within trnent of Health and Mental Hygiene. rtant: If item 27 is marked ather than ur nther traumatic event, the Medica Engineering Project Manager 5+ Government Contractor 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Jerry Dorfman Linda Garrett 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Anne Asher/Former Wife | 141 G Cambridge Street, Burlington, MA 01803 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) West Arundel Crematory 1 Burial 2 X Cremation 3 Removal from State February 14 4 Donation 5 Other Specify 2011 Odenton, Maryland 21. Signature of Funeral Service Licenser 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Exorus M00672 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Acute Fatty Liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical **X** UNPENDED AMENDED 23a,pt.II,27 per me g913 3-7-11 vt attending physician or use as the burial Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 1 Yes 2 No 3 Probably 4 V Unknown Cardiomegaly with Biventricular Dilatation Completed plnous 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other 5 Residence 6 🗸 Other: Scene After this 2 No 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death

To the Funeral Director: A
completely filled in by the fu 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. February 10, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY PAY 2011 0430 A M ANNA AGNELLO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD **COLUMBIA** BLOOM ASSISTED LIVING Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 \(\text{M} 2 \text{X} \) Days Hours oct 13, Day Year MANHATTEN, NY Director 97 089.01.9700 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 XXNo MD HOWARD **COLUMBIA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8113 TAMAR DRIVE 21045 USA "natural", or items . Was Decedent Ever in U.S. Armed Forces 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates WHITE 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NICHOLAS CORNACCHIA SANTA TARAVELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr JANICE AGNELLO DAUGHTER 8113 TAMAR DRIVE COLUMBIA, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nurial 2 Cremation 3 Removal from State cemetery, crematory or other place) **GREENWOOD CEMETERY** FEB 19, 2011 BROOKLYN ,NY 4 Donation 5 Other (Specify) 21. Sig of Funeral Service Lic P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW CLEN BURNIE, MD 21061 K. CREGORY FLYK M01148 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part i Enter the disease, shock, or heart failure. Lis Interval Between Immediate Cause (Final Onset and Death 2 heimers Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 9 Unknown funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) A55,15,60 Living Hospital Other: 2 100 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of pertifig 29c. License numbe \sqrt{D} who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

30. Name and addre

Date filed (Month, Day, Year)

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of person (921,5

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g913 3-10-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2011 J, 05A M Steven M. Arnold 0a /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES Hos Pital Baltimore SAINT Baltimore City 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1X M 2 □ F Months Days Hours **Director** 214-92-11/05/1965 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be rollified at Director 1 ☐Yes 2 No Anne Arundel Co. Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Glen Circle 21060 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Bace - American Indian 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 ş 1 ☐Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced "natural", Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Manee. Elementary/Secondary (0-12) College (1-4or 5+) 11 yrs. Marine Mechanic Maritime/ Boating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Arnold Shirley A. Schwedes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert L. Arnold / Father 21060 10 Glen Circle Glen Burnie, Maryland 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/2011 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tetatic **Physician** unknown /Medical POtens **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): Physician/Medical Records, P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 X No this certificate 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number Gebrewold M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21229 Caton 31. Date filed (Month, Day, Year) FEB 15 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registr <i>a</i> r		State of Ma	aryland		artment of F rtificate of				gien Reg. N	CUII	042	22
			1. Decedent's Name (i	First, Middle, Las	it)						2. Date of De Month Februar		ax 20 Year	3. Time of	
-	Physicia /Medic		Clara 5. Alliberong							(54			2, 2011 c. County of Death	9:00	A M
	Examin	er	4a. Facility Name (If no					4b. City, Town, o				4	Montgom		
	Funeral		Wilson Hea		e Center ex 7. Ag	e (In yrs. la	st birthday)	Gaithe If Under 1 Year	If Und	er 24 Hrs.	8. Date of Bir (Month, Da	rth		nplace (State of untry)	r Foreign
М	Director		300-18-59	71 1	□M 2 ½ F	87	Yrs.	Months Days	Hours	s Min.	Sep 23	19	23	Ohi	
	pu »		Usual Residence of De	ecedent 0b. County		10c City	Town or Lo	cation						10d. Inside Cit	y Limits
	laryla shov	5				100. Oily,		ithersbur	•					1 □Yes	2XNo
	28a-1	Director	Maryland 10e. Street and Number	Montgon er	егу	<u></u>	Ga.	10f. Zip Code	9			10g. C	Citizen of What Cou	untry?	
	3a or		419 Russ	ell Aver	ue Apt 3	01		20	877			U	nited St	ates	
	death	Funeral	11. Marital Status	<u> </u>	12. Was Decedent Armed Forces?	Ever in U.S	. 13.	Was Decedent of I		Origin? (S	pecify Yes or No Bican, etc.)	0-	14. Race - Amer Black, White		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Myddral Even. In a court by notified at	by Fu	1 ☐ Never Married 3 ☐ Widowed 4		1 □Yes 2 ☑ If Yes, Give Year or Dates:			1∐Yes 2⊠No					Specify:	hite	
21215-0036	2 hour	pel	15	5. Decedent's Ed	lucation		16a. Dece	dent's Usual Occu	pation	ant of war	king	16b.	Kind of Business/I		
215	hin 72 e. an "na Madi	Completed	(Specify Elementary/Second	only highest gra ary (0-12)	de completed) College (1-4or 5	5+)	(Give life.	kind of work done DO NOT use retire	auring m ad)	iosi oi woi	KING				
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ryla	should I and Men s marke umatic	ို	Ursel 19a. Informant's Nam	Kennet		-	19h Maili	na Address (Stree					y or Town, State, 2	?ip Code)	
Ma	d 2 sl tth an 27 Is i				nstrong/so	m							Maryland		
	f Health ttem 27 I		20a. Method of Dispos	sition		20b. Pla		osition (Name of matory or other pla		i i	Date		Location - City or		
9E	Pages ent o nt: If i		1 ☐ Burial 2 🔯 4 ☐ Donation 5		Removal from State y)		_	ney Crema		2/1	6/2011	Wc	odbine,	Marylar	nd
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. once.		21. Signature of Fune	$\Delta = C_1 X_1$	SEC	м0095	Ĝ	2. Name and Addr	ess of Fa	emati	on Serv	ice . Cl	P.O. Box Larksvill	784 e, MD 2	21029
			23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										Approximat Interval Bet	e	
	Physician	shock, or heart failure. List only one cause on each line Immediate Cause (Final											Onset and I	APR	
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Box	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent p	regnant	23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pregnar	ю				23d. Date of de Month		Year
Ö	Physician: The law requires that the death certif r this certificate has been signed by the attending ral director, page 2 should be detached for use as	by Physician/M	in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)						,	
σ.	uires that the dei signed by the a id be detached fi	Ph	Part II. Other signific	ant conditions	contributing to death b	but not resu	Iting in the I	ınderlying cause g	iven in Pa	art I.	23e. Did	l tobacc	o use contribute to	the cause of	death?
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ita	slan: ertifica ctor, p	Be C	25. Was case referre	d to medical						lace of De	ath (Check only	one)			
of Vital	Physic this co		1 ☐ Yes 2 ☐ N	ó				ent 3 🗆 DOA		Nursing I	1		6 ☐ Other (Spe	ecify)	
n c	Jing P	ö	27. Manner of Death	5 Pending	28a. Date of Inj (Month, Da	ay, Year)	28b. Time Injury	Wo	ury aτ ork? ⊒Yes 2	P∏No	28d. Describe	e now ir	njury occurred		
Division	I or Attending after death. Director: After d in by the fune	licat	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not b	e 28e. Place of In	niury - At ho	me, farm, s		_		28f. Location	(Street	Street and Number or Rural Route Number,		
Di≤	al or A after I Direct	1 Yes 2 No								tate)					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 (Check only 2 one)	Certifying Pl	hysiclan: To the best miner: On the basis and manners	of examinat	wledge, dea tion and/or	ith occurred at the nvestigation, in my	time, dat opinion,	e and place death occ	e, and due to the curred at the time	ne caus e, date	e(s) and manner a and place, and du	is stated. e to the cause(s)
	ro the vithin of the comple	Me	29b. Signature and til	tle of certifier				29c. Licer	nse numb	er		29d.	Date signed (Mon	th, Day, Year)	
	->-0			L. 17	Mila	well	mo	> 7)19	291	1	F	ebruary	12,20	11
1			30. Name and address	ss of person who	completed cause of	death (Item	23a) (Type	, Print)	0 0		10			1.0	70
3 <u>U</u>			John	R. Me	Irich	511 trar's Signat	1h	mell 1	M	. (29/TU	LILU	is Mya	. 201	17
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 ear Lewis Ε. Angelo 5:45 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Numbe If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 Year 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours February 18, 1928 Pennsylvania 204-16-4075 Director 82 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 326 West Edmonston Drive 20852 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No 1958-Black, White, etc. ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify 1987 3 Widowed 4 Divorced Specify: White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Military Officer United States Navy 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Antonio D'Angelo Marianna Cacchione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Angelo /Daughter 608 Edmonston Drive, Rockville, Maryland 20852 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprilatel4. 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Arlington National Cemetery 2011 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 ngelette Barnet M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final tarction Onset and Death Physician/ myocardia disease or condition ninutes Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinson's Disease Completed 1 ☐ Yes 2 🔑 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 \(\text{Yes} To the Hospital or Attending Physician: Twithin 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 65 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) man 0

State

Registrar

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Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month -eDruar Robert Ardison Knox 2/43 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Easton Memoria 50 al bo a If Under 1 Year If Under 24 Hrs. . Social Security Number 228-72-3308 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Min Days **Director** Yrs FL11/24/1949 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Talbot MD Bozman 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7918 Quaker Neck Road 21612 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Social Worker Social Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Benice Gordon ည Dennis Ardison 19a. Informant's Name/Relationship (Type, Print, Street and Number or Rural Route Number, City or Jown, State, Zip Code)
Paul St., #102, Baltimore, MD21202 Joshua Ardison Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Final Journey Crem. 2/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licenseg Maryland Cremation Services PO Box 1413, Baltimore, MD21203 Dorota Marshall 154 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prosician/ THROMBOTIC ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated to be a signal to be a signal to be a should to be a should to be a signal to be a signa Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 10 Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 HNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Funeral edical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) & Rainin D 00 66441 2011 February 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH 2195 WAGHNGTON ST, EASTON, MD 31. Date filed (Month, Day, Year) FEB 1 5 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 17:58 M POLONIA ebruary Physician 10,2011 EXANDRIA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 3, 1 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Maryland 15 219-45-3590 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21206 5517 Walther Avenue death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11 Marital Status Black, White, etc. 1

Never Married 2

Married 1 Yes within 72 hours after 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) School System Student 11 years marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, Be Kimberly Tidd Victor Appolonia Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5517 Walther Avenue, Baltimore, Maryland Kimberly Morosko Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 14, 2011 Sacred Heart of Mary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Synature of Funeral Service License 22 Name and Address of Facility | Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In the only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic respiratory Failure disease or condition resulting in death))/Medical Due to (or as a consequence of): Examiner Heart tailur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Cystic Fibrosis The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 XNo
9 ☐ Unknown Pregnant at time of death 5 Other (specify) ed by the at detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed to page 2 should be de þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 2 🗌 No 2 No 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes ၉ this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? the funeral 27. Manner of Death Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 Yes 2 No М s after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 - Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Hospital 29a. Certifier within 24 hou To the Funel completely fi Medical (check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Khaliah A. Johnson, MD 31. Date filed (Month, Day, Year) FEB 1 5 2011 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -Month Physician/ Sarah Hodge epruar Bacote Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours Months South Carolina Director 248-26-0526 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 XYes 2 No P.G. Mitchellville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1410 Albert Drive 20721 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No African-American þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Completed 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Nurses Aide 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Bertha Hodge Moses Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie L. Johnson-Daughter 1410 Albert Drive, Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Removal from State -18-11 Portsmouth, Virginia Greenlawn Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility WDC 20018 Bonnette & Asoc. Funeral Home 2504 28th StN.E 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. ock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to lor as a c nsequence of: Examiner onfunch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 X No 3 ☐ Probably 4 ☐ Unknown Completed should ! 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsv performed? Typerters 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) B examiner? Hospital: 2 **X**No ျ 1 🗌 Yes 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No **▼** Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the F only one 3 29d. Date signed (Month, Day, Year) 29b. Signature and Itle of certifie 45760 of person who completed cause of death (Item 23a) (Type, Print) DPINDER SINGH HOD 24

Registrar

Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland		ırtment of H <i>tificate of L</i>		Mental Hy	giene		807	
			Registrar 1. Decedent's Name (First, Middle	e, Last)		Cer	tificate of L	<i>Jeain</i>	2. Date of Dea	Reg. No.	011	3. Time of Death	
	Physicia Medic		Charlotte Brown	1					Month	Bay	2^{Year}		
	Examin										unty of Dea		
			Washington Adv	entist Hospi	tal	Takoma Park			Pri	nce G	eorge's		
	Funeral Director		5. Social Security Number 579–36–9258	6. Sex 7. Ag	e (In yrs. last i	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 7 – 1 4 – 1	h 915		ountry) Shington DC	
	how how	=	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits	
larvia	larylar 3a-f s ified	Director	MD Prince	e George's	Hyatt							1₺ Yes 2 □ No	
	or 28	<u> </u>	10e. Street and Number	- 000180 5	nyace.	34111	10f. Zip Code			10g. Citizen	of What Co	Juntry?	
	s 23a	Funeral	5821 Queens Cha	apel RD.			20783			United	d Star	tes	
တ္တ	2 should be filed within 72 hours after death with the Maryland thand Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Mar	16 1/2 00:		If	/as Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		Black, Whit		
ğ	ours a	Completed	3 ☑ Widowed 4 ☐ Divorced	Year or Dates.						Spe	cify: Bla	ack	
<u>.</u>	72 ho in "na Medio	nple	(Specify only high	nt's Education est grade completed)		(Give k	ent's Usual Occupa ind of work done a ONOT use retired)	ation <i>lurin</i> g most of wor	king	16b. Kind o	of Business	Industry	
Maryland 21215-0036	within giene er the		Elementary/Seconday (0-12)	College (1-4 or 5		Exami	,			Gover	nment		
ng	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, I	,				18. Mother's Nar	ne (First, Middle,	Maiden Surn	ame)		
<u>₹</u>	uld be I Menta narkec natic e	ř	Benjamin Stul		_			Ella Bro					
<u>a</u>	2 should lith and Me 27 is marl r traumati		19a. Informant's Name/Relations Barbara Stultz/				g Address (Street a					p Code)	
	and Hea em the		20a. Method of Disposition	Niece	20to, Place	+4UU .	13th Place lition (Name of	e NE Was	Shington Date			Town, State	
Ē	Page 1 nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cemation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State	ceme	etery, crem	atory or other place Cemeter			Washi	•	·	
Baitimore,	permit, Page Department of Important: If any injury or once.		21. Strature Tuneral Service			22.		s of Facility Jo	hn T. Ri	nines	Funer	al Home LLC	
			23a Part 1. Enter the disease, or	complications that caused	the death. D					-	0 200	Approximate	
~ F	Ph_sician/ Medical	Medical Examiner	shock, or heart failure. List of mmediate Cause (Final isease or condition resulting in death)	_a_Acu	te	ren	of fo	eller	ر			Interval Between Onset and Death	
	Examiner		Secret tally list conditions :										
<u></u>	uted d ansit		if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	a conséquenc	ce of):							
	icate be executed g physician and s the burial-transit		resulting in death) Last	Due to (or as a	a consequenc	e of):							
9/9	ificate ig phy as the		IF FEMALE:	- u									
DOX O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 house face death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Ectopic pregnancy Other (specify)	y		23d. Date of delivery Month Day Yea		,				
7. 5	that the ned by a detact	by PI	Part II. Other significant condition	ns contributing to death br	ut not resultin	g in the un	derlying cause give	en in Part I.	23e. Did to	bacco use co	ontribute to	the cause of death?	
gs,	quires en sig ould b	ted t				_			1 🗆 Y	′es 2 X N	o 3□P	robably 4 🗌 Unknown	
Hecol	The law re ate has be bage 2 shi	Completed							24a. Was a autop perfor		prior to death?	topsy findings available completion of cause of	
. 0	sian:] ertifica ctor, p	Be	25. Was case referred to medical examiner?				26. Pla	ce of Death (Chec		ZA NO	1 🗆 16	2 110	
>	Physical this call dire	욘	1 Yes 2 No		ent 2 ER/			4 ∐ Nursing H	4 Nursing Home 5 Residence 6 Other (Specify)				
0 101	tending Fleath.	Certificate:	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation		o. Time of injury	28c. Injury work? M 1 🗆	at Yes 2 No	28d. Describe how injury occurred				
	ital or At irs after c al Direct led in by		4 - Homicide determ	. (Specify)		et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
:	the Hosp nin 24 hou the Funei npleted fill	Medical	(Check 2 L. Medical E	Physician: To the best of r xaminer: On the basis of ex Nurse Practioner: To the b	kamination and	d/or investic	ation, in my opinior	 death occurred a 	at the time date an	id place, and	due to the	cause(s) and manner stated	
	To To		29b. Signature and title of certifier	70			29c. License	number) \$10	2	29d, Date sig	ned (Moint	n, Day, Year)	
_	20		30. Name and address of person w	who completed cause of de	00, (a) (Type, Pri	Poll o	tre.	Take	ma	pa	PKMD	
	Stat Registra	_	FEB 15 2011	Acres 32. Registra	r's Signat	Rad					1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02-09-2011 Constantina Binos 0015 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Director 83 0 4 9 1 5 ay, 1 9 2 7 Country) Greece 218-74-2494 Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Joppatowne 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 Che11 Rd 21085 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc ò 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 Mental Hygiene. narked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Self-Employed is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Athanasios Kalogritsas Vasiliki Koutoula injury or other traumatic should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Eleni Constantine (Daughter) 622 Harvest Ct Bel Air, MD 21014 Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Oaklawn Cemetery 02-14-2011 Baltimore, MD 21. Signature of Funeral Service Licens ^{22. Name and Address of Facility} Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year ed by the a detached f Unknown signed I significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Doknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy 2 No Yes 1 Yes funeral director, 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Tes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manyrer of Deal Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? Accident 2 No after death Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 only one Certifying Nurse Practioner: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

5 V

State Registrar Trina Mikity (1) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alyce Brown 20:20 M 02 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death maryland medical center University of Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace Country) **Funeral** -14-0576 Days Hours Min. Month, Day Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside Çity Limits Director 1 ¥Yes 2 ☐ No TIMOR 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ₩Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refred) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle azie State, Zip Code) Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Second Ht. Olive Baptist Church Cemetry 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Funeral Service Lo Name and Address of Picility reene Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Disease Heart ischemic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ģ Pregnant at time of death Month Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? performed?

Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Other: မြ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MD 1871818328 02/12/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Lauren Hawkins

31. Date filed (Month, Day, Year)

FEB 1 5 2011

MD

22

32. Registrar's Signature

S. Greene St. Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 810 Month Year Gladys Taylor Belote Medical aoll 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death He Air OF Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Mar 13, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virginia **Funeral** 1 □ M 2 🖾 F Months Days Hours Year 911 Director 231-28-5113 99 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 XYes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Linwood Avenue 21014 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify Completed 3 Widowed 4 Divorced Specify: White f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ William Taylor Winder Britannia (nmn) Gootee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Foss / Daughter 304 Linwood Avenue, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdn. 2/15/2011 Fallston, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Kathleen 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition OAA Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 Belote IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death Unknown signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 뎯 1 Yes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending Il Director: A Accident 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20b Signature and title of certifier 9c. License number Nan e and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Coleda Baird February 6:30 A Medica! 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Assisted Living Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1916 1 □ M 2 🖾 F Hours Feb 13 577-36-6349 Yrs Washington, DC Director 94 Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified 1 X Yes 2 No Silver Spring Maryland Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ě 23a Funeral 707 Kerwin Road United States 20901 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Marital Status Unk 1 ☐ Never Married 2 ☐ Married Black, White, etc. 0 Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural" 3 Widowed 4 Divorced Black 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry unk (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 shours.

jartment of Health and Mental Hygs...

-rant: If item 27 is marked other th

-ther traumatic event, thy the Office Worker US Marine Corp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Sloan/Guardian 1350 Beverly Road Suite 115-123 McLean, VA 22101 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department or Important: If any injury or once. 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/14/2011 Woodbine, Maryland 21. Signature of Funeral Service Lie Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Atherosclerotic Coronary Artery Disease years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a consequence of Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 XNo 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Essential Hypertension 24a. Was an has autopsy performed this certificate 2 D No 1 Tes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 😿 Other (Specify Assisted-1 ☐ Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

P.O. Box 68760 Records, Division of Vital e Hospital or Attending Pl 124 hours after death. e Funeral Director, After th leted filled in by the funeral

State Registrar HMH 17 Rev 7/2009

(Check only one)

Cynthia M. Williams,

war's Signatur

nthia M Nelliams, DQ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

February 10,2011

29c License number

DO 3720 Upton Street, NW Washington, DC 20016

H0058032

11-01035 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Willie Junior Black, III State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day February 6, 2011 Medical Examiner Willie Junior Black, III 1550 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Elkton Cecil 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours 1X M 2 F 23 Country) Delaware Yrs 04/31/1987 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f shor must be notified at once. 1 Yes 2 X No New Castle New Castle be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 Wildel Avenue 19720 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Specify: Black 4 Divorced Yes, Give Year or Dates: 1 Yes 2X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) t. Pages I and 2 should be filed within 72 ho trment of Health and Mental Hygiene. ortant: If item 27 is marked other than "ny y or other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A Unemployed Unemploved 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ William Black, Jr. Emily Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Baldwin (Mother) 316 Wildel Avenue, New Castle, DE 19720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State permit. Pa.
Department or.
Torortant: If it crematory or other place) 1 Burial 2 Cremation 3 Removal from State Jones Cemetery Clarkton, NC Donation 5 Other Specify: 1. Sign Jure of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part . Enter the disease, or complica tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. /Medical Between Onset and Methadone Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of); Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): Exa events resulting in death) Last Physician/Medical AMENDED 23a, 27, 28a-f per me g914 4-6-11 vt X UNPENDED attending physician or use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 V Yes 2 ☐ No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Director: I in by the f within 24 hours after death.

To the Funeral Director: Pending 1 Yes 2 X No fd 1:52pm fd 2-6-11 unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 28f. Location (Street and Number or Rural Route Number, City Suicide or Town, State)
Willow Dr. Elkton, Md. determined Homicide at home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. February 7, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Suzanne Julia Beicken Physician/ February 13, 2011 6:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince George's **Examiner** Beltsville Hillhaven Assisted Living If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 09/04/1944 1 M 2 X Months Hours 002-34-7311 Director 66 Yrs. Usual Residence of Decedent 23a or 28a-f shov ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits University Park Prince George's 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4320 Van Buren Street 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 2 **X** No Baltimore, Maryland 21215-0036 Yes White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 5+ Lecturer Education marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Haas ဂ္ Bartel Leo permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Peter U. Beicken / Spouse 9b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code, 4320 Van Buren Street, University Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Final Journey crem. 1 Burial 2 Cremation 3 Removal from State 2/27/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Derota Marshall 22. Name and Address of Facility
Maryland Cremation Services overte Box 1413, Baltimore, PO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition METASTATIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year i signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been si should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2: autopsy performed? Yes 2 N death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4XX Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number アシこここ FEBRUAR

State Registrar

DHMH 17 Rev 7/2009

THOMAS

31. Date filed (Month, Day, Year)

20770

4 Rulling

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 755Z

32. Regi

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Donald Paul Beck Physician/ February 12, 2011 5:05 am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Timmonium** Examiner Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 05/23/1954 1 🔀 M 2 🗆 F 215-66-2853 Director 56 MD Usual Residence of Decedent e filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Randallstown MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 21133 Funeral 23 Ojibway Road 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces' Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Ind Mental Hygiene.

S marked other than "natura umatic event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Marine Tech - Welder Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marcella Conrad ပ John Henry 19a. Informant's Name/Relationship (Type, Print)
Patricia Beck / Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 23 Ojibway Road, Randallstown, MD 21133 per it. Page 1 and 2 Decartment of Health Important: If item 27 any injury or other th Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2/17/2011 Woodbine, MD Final Journey crem. 22. Name and Address of Facility Cremation Services 21. Signature of Funeral Service Licensee Doorta Marshall Baltimore, MD21203 1413, PO Box 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impory Due to (or as a consequence of): the attending physician and hed for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Yes 9 Unknown Unknown seen signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 **X** No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 32. Regist ar's Signature

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State Registrar

FFBRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wilbert Physician/ Salisbury Blake Month Day Year 5:50a™ Medical 12,2014a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Village Care & Village Rehal Montgomery Montgomery 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-28-5559 1 🛣 M 2 🗆 F Months Days Hours Min Director 79 /15/1931 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Village Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19301 Watkins Mill Road 20886 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2K No Specify: If Yes, Give Black 3[™] Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Brickmason 12 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Wilbert Blake Veronica Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Blake Son 3801 Kenilworth Ave., Bladensburg, MD, Apt. 2096 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey crem. 2/27/2011 Woodbine, MD 21. Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD2 lla, Sha M Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 下にろかったトトラ disease or condition resulting in death) EMERICOLYA Medical Due to (or as a consequence of) Examiner Comon Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami or Attending Physician: The law requires that the death certificate be executed C 2 5 sician and burial-trans 3500A5E KIBNE that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 🗌 No g 🗌 Unknown the 9 Unknown ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been signated by page 2 should by 1 ☐ Yes 2 🕏 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a. Was an autopsy performed? Yes 2 X No this certificate h 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: XXNursing Home 5 Residence 6 Other (Specify) ျပ 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident
Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State edical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examin 7. In the basis of elemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Number Practionals To the Destruction of the wildow, death occurred at the time, date and place, and the cause(s) and manner operated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 40050280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 MOLECULAR DR ROCKVILLE, MI) MI) 4 MUShiravar)Adcar 1. Date filed (Month, Day, Year) Registrar's Signatur

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert B. Brown February 2011 5:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2429 Meadow Road Dundalk Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours March 12, 220-14-3517 85 Director Warren. Maryland Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location with the Maryland Director Maryland Baltimore Dundalk 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21222 **USA** 2429 Meadow Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ ò 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify. White If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years 5 + years Construction Supervisor Steel other Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Marie Tracy Joseph Henry Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 660 Pelican Bay Drive, Daytona Beach, Florida 32119 Lynn Conway Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🄀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)
Dulaney Valley Memorial February 17, Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility.
Connelly Funeral Home Of Dundalk, P.A. Kant 7110 Sollers Point Road, Dundalk, Md. 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Yes 2 ☐ No ed by the a 1 L Yes 2 L 9 Unknown Division of Vital Records, P.O. cate has been signed I page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 🗌 Probably 4 🗌 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month. Dav. Year)

Registrar

State

31. Date filed (Month, Day, Year) FEB 1 5 2011

BRW

DHMH 17 Rev 7/2009

DULANEY VALLEY RD THONIUM MD ZIOG3

cause of death (Item 23a) (Type, Print)

11-01043 Robert Clark Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Clark		ne	2011			
Physic	ian/	1- For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	- 2 Da	Reg. No.	CUII	1423
Medical Exam		Robert Clarke .	Jr. Mo	onth Day bruary 7, 201	Year 1	3. Time of Death 0218 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location Sinai Hospital Baltimore			County of Death	_
Funeral			Jnder 24Hrs. 8. D	ate of Birth (MM/D	DD/YYYY 9. Bir	
Director			ours Min.		Foreig	
ány.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		urci i ij	114	
.	١	1 Line of City				10d. Inside City Limits 1 Yes 2 No
Marylau 28a-fi d at on	Director	10e. Street and Number		10g. Citize	en of What Coun	
death with the Maryland or items 23a or 28a-f show must be notified at once.	Ö		5	1	USA	
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Conference	Origin? (Specify Y can, Puerto Rican,	es or No- 1 etc.)	14. Race - Americ White, etc.	can Indian, Black,
after de	by Fu	Vidowed 4 Divorced if tes, give teer	cify:	s	Specify: B	ack,
hours natur	ted t	45 Deceded 5 Street 10 17	ive kind of work dor		ind of Business/Ir	
)36 thin 72 ne. than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	20	St	-L F	on Dart
15-0036 filed within 72 hours after death with the Maryland Hygiene. 40 other than "natural", or items 23a or 28a-fahe 5, the Medical Examiner must be notified at once	ပ္ပ	17. Father's Name (First, Middle, Last)	ther's Name (First, I	Middle, Maiden S	Surname)	re agoi.
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", natic event, the Medical Examiner.	o Be	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	adge.	Hoche	aday	
- 0 a	5	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Ni 19b. Mailing Address (Street and Ni 308 W 103 v 1.5	Number Rural Ro		y or Town, ate,	Zip Code)
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or T	
		4 Donation 5 Other Specify: Covambia Memorial		2011 Co	lumbio	a MD
Baltim permit. Pag Department Important: injury or o		21. Signatur of Funeral Servi Licensee 22. Name and Address of Facil			neral	Home
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	s cardiac or respira	atory arrest, shock	SSUP, k, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Car			10.00	Between Onset and Death
.1		or condition resulting in death) Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause				
, 9x =	Examiner	Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed an and life transit	al E	d				
sicii be	edical	▼ UNPENDED	4 4-1-11			
Division of Vital Records, P.O. Box 6876C the Hospital or Atteoding Physician: The law requires that the death certificate in 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physiphetely filled in by the funeral director, page 2 should be detached for use as the bit.	Physician/M		pic pregnancy		Date of delivery onth Da	ay Year
Sox (leath ce e attence for use	ysici	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		_		•
O. E. at the c d by th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I. 23e	e. Did tobacco use	e contribute to th	ne cause of death?
Division of Vital Records, P.O. In or Atteoding Physician: The law requires that the rs after death. al Director: After this certificate has been signed by ited in by the funeral director, page 2 should be detach	ed by	Chronic Obstructive Pukmonary Disease, Dementi	<u>ia</u> 1	Yes 2 N	No 3 Proba	ubly 4 🗹 Unknown
cords law requi	ompleted		248	a. Was an autopsy	prior to cor	ppsy findings available mpletion of cause of
ital Rec iein: The l s certificate b rector, page	ပ			performed? Yes 2 No	death? 1 ✓ Yes	2 No
Vital ysician: his certi director	m l	eyaminer?	th (Check only one) Nursing Home		e 6 Other:	
ing Phy After th	٦ ا	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Wor		scribe how injury		
Sion Atteodir death.	Certification:	Natural 5 Pending 1 Yes 2 Accident Investigation				
Divis	Prtifi	3 Suicide 6 Could not be determined (Specify) Suicide (Specify)		ation (Street and Fown, State)	Number or Rura	I Route Number, City
Divis To the Hospital or / Within 24 hours after To the Funeral Dire completely filled in b		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	lolace, and due to the	ne cause(s) and m	manner as stated	
To the Howithin 24 h	gi	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	occurred at the time	, date and place,	, and due to the o	cause(s)
0	2	29b. Signature and title of certifier 29c. License number O.C.M.E.	ır		te signed (Month	n, Day, Year)
The state of the s	ŀ	30. Name and address of person who completed cause of death (Item 23a)		Feblua	ary 7, 2011	
FIRE		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street,	, Baltimore, M	D 21223		
Sta Regist		31. Date filed (Month, Day, Year) FFR 1 5 2011 August 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 114238 State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month M February 8 2011 2:27P Robert James Cosgrove, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Balto. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Country) Pennsylvania Months **Director** 85 February 211-12-8490 1926 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Balto. Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 6504 Hazelwood Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1944-1946 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 4^{College (1-4 or 5+)} Bethlehem Steel General Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fisherships is marked o t. Page 1 and 2 should be fill trent of Health and Mental rant: If item 27 is marked or ည John J. Cosgrove Jeanette Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Cosgrove Spouse 6504 Hazelwood Court Rosedale, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Gardens of Faith 2-11-2011 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home B 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ cardiany disease or condition Due to (or as a consequence of) schowic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death been signed by the a should be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? 2 of Vital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 1 Yes မ 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Division s after death. Accident Investigation 3 Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature title of certifier 6X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1HARUES 6701 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 State Registrar	Cei	rtificate of L		, ,	Reg. No.		
Physic	ian/	1. Decedent's Name (First, Middle, Last)	2. Date of Month			th	3. Time of Death		
	lical		Rebru			Y 11 7011			
Exam	iner	4a. Facility Name (if not institution, give street and number) Seasons' Hospice		Llstown		4c. County of De Baltim			
Funera	al	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year		8. Date of Birth		Birthplace (State or Foreign	
Directo		578-42-1483 1 M 2 AF	78 Yrs.	Months Days	Hours Min.	(Month, Day, May	Year) (Country) Germany	
nd now	٦ٍ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
arylar ta-f st	Funeral Director	MD Baltimore	Gwynn					125 Yes 2 No	
the M or 28 e not	ä	10e. Street and Number	Gwynn	10f. Zip Code		1	10g. Citizen of What	Country?	
with s 23a nust b	era	4010 Buckingham Rd.		2120	07			States	
death item			rer in U.S. 13.	Was Decedent of Hi	ispanic Origin? (Spe In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian,	
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by		Jo	1 ☐ Yes 2 ☐ Ho			Specify:	White	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", o my injury or other traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specificantly bightest readication)		dent's Usual Occupa			16b. Kind of Busines		
121; In 72 In 72 In 74 In 72 In E E	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+	lifo D	kind of work done d O NOT use retired)	during most of work	ing		,		
d with	BeC	+2	Ho	me Health			Health	Care	
and be filed ental Hyg ked oth c event,	일	17. Father's Name (First, Middle, Last) Unk Unk			18. Mother's Name		Maiden Surname)		
Maryland 2121 should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the Me		19a. Informant's Name/Relationship (Type, Print)	19b Mailir	an Address (Street a		Unk I Route Number	City or Town, State, 2	Zin Code)	
od 2 st balth a n 27 is		Kim Miller /POA	I .	•		·	allstown,	,	
or other		20a. Method of Disposition 1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State	20b. Place of Dispo	sition (Name of natory or other place	e) [Date	20c. Location - City	or Town, State	
Baltimor permit. Page 1 Department of Important: If it		4 ☐ Donation 5 ☐ Other (Specify)	Chesap	eake Crem	atory	Feb 12 2011	Beltsvi	lle, Maryland	
Baltimol permit. Page 1 Department of Important: If i any injury or or		21. Signature of Funeral Service Licensee	01443 22	Name and Addres	s of Facility of Fu	neral Al	ternatives		
		23a. Part 1. Enter the disease, or complications that caused to	he death. Do not ente	8717 Gre	een Pastur a such as cardiac o	es Drive	Towson Mai	ryland 21286 Approximate	
Physician		Immediate Cause (Final	urombotic e		g, odor ao odraide c	r respiratory arre	51,	Interval Between Onset and Death	
Medica	E I	disease or condition	consequence of);						
Examine		athero.	scierotic c	ardio vasci	ular Dist	ase.			
p #	Examiner	if any, leading to immediate Due to (or as a cause. Enter Underlying	consequence orj:						
ecuter and -trans	Xan	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a	consequence of):						
8760 tificate be executed ng physician and as the burial-transit		sas to let as a	oonooquenoe oi).						
8760 tifficate b ng physic as the b	Medical	d							
x 68		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy Fetal death 3	Ectopic pregnancy	· ·		23d. Date of delivery		
Box death of the atterned for u	Physician/	in the past 12 months? 1 Yes 2 No 4 Pregnant at 1 9 Unknown 9 Unknown	Other (specify)	y 		Month	Day Year		
that the		Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e Did tot	asco use contribute	to the cause of death?	
S, F	d by			nash, mg samos giri	o, , , , , , , , , , , , , , , , , , ,			Probably 4 Unknown	
ord requ	lete					24a. Was ar		utopsy findings available	
OT VITAI HECONTAS, Ig Physician: The law requires ter this certificate has been signeral director, page 2 should b	Completed					autops perforr	y prior to ned? death?	completion of cause of	
al F	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Check	1 Yes 2	P Mo 1 ⊔ Yo	es 2 No	
hysic his ce	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	Other:					
JOT Jing P J. After t	ertificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day,	Year) 28b. Time of injury	28c. Injury work?	at 2	8d. Describe ho	w injury occurred		
SIOI Nttenc death ctor: /	ļį.	2 Accident Investigation 3 Suicide 6 Could not be	- At home, farm, stre		Yes 2 No				
DIVISION Of VITAI RECORDS, P.O. BOX 63 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director After this certificate has been signed by the attendification in the funeral director, page 2 should be detached for use	0	4 Homicide determined 256. Place of Injury building, etc.		or, ractory, office		City or Town	n (Street and Number or Rural Route Number, Town, State)		
lospit t hour unera	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
the F thin 24 the F mplet	Me	only one) 3 L Certifying Nurse Practioner: To the be	est of my knowledge, d	eath occurred at the	time, date and place	e, and due to the	cause(s) and manner a	s stated.	
5 With 6 00 00 00		29b. Signature and title of certifler MSRY MANNE M.D		29c. License	number 057465		9d. Date signed (Mon		
			th (Item 23a) (Time D				111/5		
HV		N. S. Rajapakse M.D. 28	35 Sm17	nAv. s	- 203 -	Baltik	nore, M	D. 21209	
Sta		31. Date filed (Month, Day, Year) 32. Registrar's	Signature						
Regist	rar	FEB 15 2011 Server \$	parked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12sbeth Coleman Month 9:22 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bel timore Baltimore Harbon If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 □ M 2 🗹 Months Hours Min Director show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No ō 10g. Citizen of What Country Funeral 23a 106 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Dever Married 2 Married ō þ 1 Yes 2 No If Yes, Give Year or Dates Slack "natural" 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. ONOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Be Eather's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ 19b. Mailing Address (Street and Number or 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signatur of Funeral Service Licensee Vaughn C Fire Such as c Greene Funeral Natima 23a. Part 1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) onter Coronario Medical Due to (or as a consequence of) Examiner yens theroscler Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed? 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 No 2 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident

To the Hospital or Attending Physician: The law requires that the death certificate be executed and physician a the burial-P.O. Box 68760 attending ph I for use as th ed by the a detached f been signed by should be detach Records, this certificate has Division of Vital within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Medical

Saltimore, Maryland 21215-0036

Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year)

vensos

D6879

3001 S. Hanover

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stevenson H21601

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Catherine M. carson 20:03 2011 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 0ct 13, 1936 Director 213-32-1073 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location with the Maryland Examiner must be notified at Director 10d. Inside City Limits 1 Tes 2 XNo MD Anne Arundel Glen Burnie 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1410 Scanlan Dr 21061 USA items ? 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 XX Married "natural", or þ 1 ☐ Yes 2xxx No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3 Divorced 4 Divorced White Completed er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within Food Service AACO Schools other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed of Health and Mental H If item 27 is marked ot rr other traumatic ever ပ္ Chester Harvey Bennett Margaret Olivia Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Carson, Sr Husband 1410 Scanlan Dr., Glen Burnie, MD 21061 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crownsville Veterans Cem | Feb 14, 2011 Crownsville, MD Sign // of Funeral Service Lic. Name and Address of Facility Fink Funeral Home, P.A. k. Cregary M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Septicemia Medical Due to (or as a consequence of) Examiner Prieumonia Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 🔀 No Day Pregnant at time of death Month Year been signed by the should be detached 1 ☐ Yes ∠ µ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by myocardial Infarction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes <u>ا</u> 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 **∑Certifying Physi⊏ian:** To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 1871818328 2/8/2011

Registrar
DHMH 17 Rev 7/2009

State

Lauren

31. Date filed (Month, Day, Year)

Baltimore, MD 21201

22 S. Greene St.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Hawkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Paul E. Custer 201^{Ye} 5:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 118 E.Aylesbury Road Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Dec. 13 1X M 2 . F 89 Year 1921 220-16-5933 West Virginia **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 118 E. Aylesbury Road 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Divorced 4 Divorced d Mental Hygiene. marked other than "natural matic event, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Technician Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Gilmore H. Custer Mary Belle Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Custer/ Son E. Aylesbury Road Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place)
Dulaney Valley Mem. Cons. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/16/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Rick Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has I autopsy performed? death? 2 🗌 No . Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 - No Other: ျ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 ucu nth, Day, Year)
5 2011

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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Virginia Lee Corbi 02 2011 $1:00A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4749-L Flanders Lane Anne Arundel Harwood Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min Yrs 62 MD **Director** 214-56-2250 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Harwood 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 4749-L Flanders Lane 20776 U.S.A. items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married ğ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: and Mental Hygiene. Specify: Completed 3 X Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Insurance Underwriter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Spruil1 Cecil Simmons Virginia Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Mr. Christopher Jones/Caretaker 4749-L Flanders Lane Harwood, MD other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō <u>∓</u> 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ò permit. Page Department of Important: If any Injury or Good Shepherd Cem. 02/21/2011 Ellicott City, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a con whence of): **Examiner** Sequentially list conditions. Examine Duri to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 g g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed It 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 2 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy perform Division of Vital funeral director Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 2 🗂 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manpér of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 🗹 Natural 5 Pending within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

FEB 1 5 2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 16264 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Cummins Physician/ February 7 3:00 A. M Cohan Barbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Collingswood Nursing Home <u>Rockville</u> ${ t Montgomery}$ If Under 1 Year Date of bits. (Month, Day, Yea -1 25 Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 🗆 M 2 🛛 F Months Director 80 Yrs 292-24-5563 1930 Ohio Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No <u>Maryland</u> Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1932 Dundee Road 20850 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify. 3 🗆 Widowed 4 🗆 Divorced White Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Social Worker Montgomery County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ewe ဂ္ Charles Mason Margaret Curtin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Cohan / Spouse 1932 Dundee Road, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of February 20c. Location - City or Town, State Montgomery
Crematorium, Inc. 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Rockville, I 800 W. Montgomery Avenue, Rockville, MD 20850 Signature of Funeral Service Lig Haron M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Days Medical Due to (or as a consequence of): **Examiner** Failure to Thrive Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No after death.

Director: After this certificate Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 🗶 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 X No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 XNatural injury 5 Pending Accident M Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral L 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) D0062435 February 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Rockville, Maryland 20850 Elsayyed Sayed, M.D., 31. Date filed (Month, Da State Registrar

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Registrar

State

Gary E.

31. Date filed (Month, Day, Year)

Name an address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

D.O.

Raffel,

FEB 15

H45839

5413 West Cedar Lane, Suite #203C, Bethesda, Maryland 20814

February 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18perFH, G912, 2/24/2011, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician/ Month aM amos Februar 201 9:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2605 Chapel Lake Drive # 303 Gambrills Anne Arundel 5. Social Security Number 200-22-1551 8. Date of Birth (Month, Day, Year) 10/19/1930 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Min. 1 🕱 M 2 🗆 F Months Hours 80 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items on other trainmain. 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** Gambrills MD Anne Arundel 1 ☐ Yes 2 No 10f. Zip Code 21054 10g. Citizen of What Country? 10e Street and Number 2605 Chapel Lake Drive Apt. 303 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No Armed Fyes, Give 1 0 / 8 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1X Yes 2 No Army
If Yes, Give
Year or Dates, 1948-51 þ 1 Never Married 2 Married White 1 Yes 2 X No Specify: Specify: Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) OSHA Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Daniel Concannon Martha aine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine A. Concannon Wif 2605 Chapel Lake Dr., #303, Gambrills, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20a. Method of Disposition
1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Woodbine, MD 2/16/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Do Doorta Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode f dying, such as car Approximate shock, or heart failure. List only one cause on each line. Interval Bet Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Month Year Pregnant at time of death 1 Yes 2 G 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate by 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nuffee Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who cause of death (Item 23a) (Type Print) Shan 31. Date filed (Month, Day, Year) State 5 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 14, 2011 Physician/ Robert Daniel Crowley 1:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sabillasville Frederick 16834 Buck Lantz Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) Days April 17, 1930 Hours Min. 1 X M 2 - F California 579-36-8781 80 Yrs. Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 K No Sabillasville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 16834 Buck Lantz Road 21780 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 Divorced 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Religion Clergy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Marguerite McGee Dale Spofford Crowley and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16834 Buck Lantz Road, Sabillasville, Maryland 21780 Health tem 27 Elizabeth L. Crowley/Wife other item Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Parklawn Memorial Parklawn Memorial 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State February 17, 2011 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ eronary disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Ten Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continues that the death certificate be executed. abet Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical am P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 Ato To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 🕇 6 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 2060396

****.3

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Murshed

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12, 2<u>011</u> Physician/ February 5:35 P M Elaine Deeds Sigrid Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore <u>Arden Courts of Towson</u> Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F North Dakota Director Yrs. 501-16-7303 87 Nov 16, Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 X No Baltimore Phoenix Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a USA 21131 14002 Manor Road Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Health Professor Emeritus Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grande Amanda Irene Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sydney Laine James/Daughter 14002 Manor Road, Phoenix, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) 2/15/11 Atlantic Crematory Glen Burnie, Maryland of Funeral Service Licensels 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. Padonia Road, Timonium. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (First disease or condition resulting in death Physician/ Dementa DILCATUNS 1cus Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) ASSISTED Director: After this d in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) Medical trifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifie

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

670

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1tan ves

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G912,2/24/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. edent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 9:00 AM 201 ever Medical not_institution, give street **Examiner** 4b. City Town, or Location of Death 4c. County of Death 7 MOTE last birthday) If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min Country) Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No nore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Funeral 11214 bilee 2020 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White Completed by 1 Never Married 2 Married いとのじょん レングラ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation

(Give kind of work done during most of working 16b. Kind of Business Industry fe. DO NOT use retired) College (1-4 or 5+) Be r's Name (First, Middle, Last 18. Moth မ nda e 19a, Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij 2020 *leresa* our 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 2-18-11 areenmount Itimore lame and Address of Facility Wighn C Greene 50 Baltmore Signatu of Funeral Service Lic tunera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Infarcts Physician/ Medical Due to (or as a consequence of): Examiner ears Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director; After this certificate has t completed filled in by the funeral director, page 2 s performed? death? 2 🗌 No Be (25. Was case referred to medica examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c, Injury at work?
1 Yes 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2569 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Hospital 5601 LOCK-PAVEN BLVD BALTIMORE 31. Date filed (Month, Day, FEB 1 5 2011 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner 7/2 TMOV Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Country) 216.28.0448 1 🗆 M 2 💢 F Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Funeral Director Baltimore Baltimore 1 🗆 Yes 2 🔀 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6518 Woodgreen 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Be Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Gordon's Seafcod Cook ovade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Merriman Anna Tendle. ساطhalth an. ۳**۱۰ 27 is m**. ۴۳۳ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD 21207 Bailey Meadow Road permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 6 1 Burial 2 Cremation 3 Removal from State 02 22 2011 Baltimore, MD injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Vallahr Greene Pureral Vauge Kandallstown. Krad 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause F al disease or condition Physician/ erosc Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to ior as a consequence of Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a l be detached f g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 2 XN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 2 \ No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred i or Attending F after death. injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Hospital Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print) Name and address of person who

Registrar

DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

15 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Peter James Dra	_	1- For State	ate of Marylar	•	artment of rtificate of		d Mental I	-	2 N I I	N4251	
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Midd Peter James						2. Date of Deat Month February 7		3. Time of Death 1815 hrs	
	ı	4a. Facility Name (if not institution 708 Biddle Street	n, give street and num	nber)		b. City, Town, or Chesapeak	Location of Dea		4c. County of Dea	ath	
Funeral Director		5. Social Security Number 381–86–6901	6. Sex 7	'. Age (In yrs. la 4		If Under 1 Yea Months Day		n	4, 1965		
faryland 28a-f show any	tor	Usual Residence of Decedent 10a. State 10b. County MD Cecil		10c. City,	Town or Locati Chesap	eake Cit	ty			10d. Inside City Limits 1 X Yes 2 No	
0036 within 72 hours after death with the Maryland joine. rer than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	ral Director	10e. Street and Number 708 Biddle Str 11. Marital Status	12. Was Dece		S. 13. Wa	Decedent of His	1915 spanic Origin? (§	Specify Yes or No-			
rs after death ural", or iten miner must.	by Funeral	1 Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe	ces? 2 X No	1	Yes 2 No	n, Mexican, Puerl specify: tion (Give kind of		White, etc. Specify: W	hite s/industry		
5-0036 led within 72 hours Tygiene. other than "natur	Completed	Elementary/Secondary (0-12)	College (1-4		during mo	ost of working life cape Arc	DONOT use re	tired)	Landsca		
21215-	B	Stephen V. Dragosh Faye D						e (First, Middle, Maiden Surname) Wittmann Rural Route Number, City or Town, State, Zip Code)			
re, MD s 1 and 2 sho f Health and if item 27 is er traumati		Stephen V. Drag		20b. F	5576 Place of Disposi	Wild Iri	is Lane		, Michigan 20c. Location - City	48840	
Baltimore, pernit. Pages 1 a Department of He Important: If ite	ł								Mason, Mi		
Physician Medical	4	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.		Do not enter th	e mode of dying,				Approximate Interval Between Onset and Death	
<i>E</i> xaminer	niner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c	onsequence of	f):						
oe executed cian and urial - transit	dical Examiner	events resulting in death) Last UNPENDED	Due to (or as a c	onsequence of	f):						
lox 68760 eath certificate b a attending physi for use as the bu	릙	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Other (Specify) 9 Unknown						nancy	23d. Date of delive Month	ery Day Year	
res that the d signed by the		Part II. Other significant condit	ions contributing to c	death but not re	esulting in the u	nderlying cause g	given in Part I.			to the cause of death?	
tal Records, cian: The law requir certificate has been s ector, page 2 should	Completed by							24a. Was a autop: perfor 1 Yes 2	sy prior to med? death?		
n of Vital ling Physician: After this certif funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 28. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Injury at Work? 28. Describe how injury occurred								er: Scene	
Division of Vital Records, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending Investigation 3 Suicide 4 Homicide Pounding Investigation 4 Department of the determined Pounding Investigation 5 Pending Investigation 5 Pending Investigation 6 Could not be determined (Specify) Single Family Home FOUND: 1 Yes 2 No Subject shot self FOUND: 1 Yes 2 No Subject shot self Subject shot self Subject shot self Subject shot self 28f. Location (Street and Number or Rural Route Number, City or Town, State) 708 Biddle Street, Chesapeake City, MD									
DIVI: To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in t	edical	one) 2 Medical Exa	nysician: To the best of miner:On the basis of and manner state	examination ar		on, in my opinion	, death occurred		and place, and due to	the cause(s)	
		29b. Signature and title of certifie	Hello	i a	00.1	29c. Licens			29d. Date signed (M		
0			sistant Medical E	xaminer 9	900 W. Balt	more Street,	Baltimore, N	1D 21223			
Sta Regist	ite	31. Date ELEMINTS DZOTT	Deve 32. Regi	istrans Signatu	arre						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death v 5,2011 Physician/ February 2130 Anderson Davis George Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Months Hours Min. July II Maryland 212-20-9209 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the remainstrained Health and Mental Hygiene.
Health and Mental Hygiene.
Health and Mental Hygiene.
The marked other than "natural", or items 23a or 28a-f show then 27 is marked other than "mast be notified at other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 15007 Eastway Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed Black Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Howard University Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Hall Davis Catherine Eva Frye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15007 Eastway Drive
Silver SPring, MD 20905 19a. Informant's Name/Relationship (Type, Print) James H. Davis/Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or ot cometent crematory or other place)
Howard UNIVERSITY
Medical School 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Feb 7,2011 Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home Bluntar Ca M00969 3821 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to make the sequentially list conditions, Septic Shock Examine Due to for as a consequence cause. Enter Underlying Cause (Disease or iinjury Bowel Obstruction-Acute and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical that the death certificate be Respiratory Failure Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the a a Unknown g | Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death.
Puneral Director: After this certificate has been sign Recurrent Pnuemonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Lymphoma 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending 1 🗌 Yes 2 🔲 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) D0065069 , au

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Dignature

1500 Forest Glen Road, Silver Spring,

MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Sirak Lemma,

31. Date filed (Month, Day, FEB 1 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Physician/ 10, 2011 11:50P M Benjamin Henry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill- Bethesda Montgomery Bethesda If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Feb 13, Year 924 1 XM 2 - F Days New Hampshire Director 86 578-40-3938 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director Bethesda 1 Yes 2 X No Marvland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a United States 20816 Apt 818 5101 River Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Private Law Firm Lawyer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be Theda Fulton Benjamin Henry Dorsev of Health and It item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie G. Dorsey/daughter 10204 Garden Way Potomac, Maryland 20854-7733 Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 2/15/2011 Woodbine, Maryland Signature of Funeral Service Lisepsee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 MDHomas Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Renal Failure Medical Examiner Due to (or as a consequence of): Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Cate of injury (Month, Day, Year) 28b. Time of 28c. Injury at Director: After 1 XNatural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Contifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

FEB 1 5 2011

32. Registrar's Signature

Susan J. Miller, M.D. 8218 Wisconsin Avenue, #305 Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month February 2011 Physician/ Pay 10:15 P M Ρ. Detze1 Louise Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Age (In vrs. last birthday) Funeral (Month, Day, April 10. Days Min. 1 □ M 2 🏻 F Months Hours Washington, D.C. Director 83 579-30-0414 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at Director 1X Yes 2 ☐ No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 20851 United States 203 Twinbrook Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11 Marital Status Armed Forces Black White etc. "natural", or þ 1 Never Married 2 Married 1 Yes : 2 X No 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 X Divorced Completed White Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County than College (1-4 or 5+) Elementary/Seconday (0-12) Special Education Teacher's Aide Public Schools 12 and Mental Hygier Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ည Margaret Murphy Louis A. Ploettner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 703 Ridgemont Avenue, Rockville, Maryland 20850 Donald J. Detzel, Jr. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 15, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ My o cardi disease or condition resulting in death) Medical Due to for as a consequence of) Examiner as Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examine Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death signed by the sid be detached f 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

13

(Check

only one

29b. Signature and title of

30. Name and address of person

mc

DHMH 17 Rev 7/2009

State Registrar 9901

completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's signatur

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

medical Car

62553

29d. Date signed (Month, Day, Year)

February 11,2011

2085

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 11, 2011 ucille 10:50 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Heron Point Nursing Home Chestertown Kent 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days Hours Aug. 10, Year 925 Months New York 85 Director 108-26-1230 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director Chestertown 1X Yes 2 ☐ No Maryland Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 501 East Campus Avenue 21620 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: White Specify. "natural", 3 Nidowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 in the filed within 72 in the filed within 12 in the filed page 1 is marked other than "many or other traumatine manner." College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Grant Macbeth Orpha Pearl Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Decker/Son 8621 Irvington Avenue, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Montgomery crematory or other place) 1
Burial 2
Cremation 3
Removal from State February Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Crematorium, Inc. 21. Signature of Funeral Solvice Licensee Bethesda-Chevy 22. Name and Address of Facility Robert A. Pumphrey Funeral Home M00198 <u>7557 Wisconsin Avé., Bethesda,</u> 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Izheime years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of If any, leading to immedicause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Por in the past 12 months?
1 ☐ Yes 2 No Dav Pregnant at time of death 5 Other (specify) Month Year signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy performe 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner's Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending injury death. 1 Yes 2 No Accident
Suicide Investigation after death Director: / the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fund completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D004 14-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

FEB 1 5 2011

21620

Helen Noble, M.D. 122 Speer Road, Suite 5, Chestertown, Maryland

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EBRUAR. Lester B. Dowell, Jr. 201 2.45A 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER BURNIE Clen ANNE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Day, Months Hours Min. 215-64-3142 Director 55 Yrs Usual Residence of Decedent 10a. State 10b. County death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland | Anne Arundel 1 Yes 2 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1634 Furnace Drive 21060 United States 11. Marital Status . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Forces?

1 Yes 24 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Completed 3 \square Widowed 4 \square Divorced Specify. "natural" Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) 9th College (1-4 or 5+) Demolition Man Construction Important: If item 27 is marked other any injury or other traumatic event, it Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Burgess Dowell, Sr. Betty Lou Bergen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Dowell / Wife Furnace Drive, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of 1 Burial 2 XCremation 3 Removal from State Atlantic Crematory,LLCFeb. $_{12}$,2011 $\!$ Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AMEROSE FUNERAL HOME, INC. 1328 Sulphur Spring RD., Arbutus, Maryland 21227 alluid 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death METACTATIC Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has I autopsy performed certificate 2 🗆 No 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? ☐ Accident☐ Suicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dona Dorsey Month Year 5:45 February Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Street Ashley Home Linnard Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, OS 25 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Year) **Director** 89 266-26-1276 FI "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 767 Linnard Street 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Black 3 X Widowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Baltimore City Elementary/Seconday (0-12) Ukn College (1-4 or 5+) Custodian Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie McClellan Gertrude Sweet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) God Rosalind McDaniel-Daughter Caitlins Ct, Baltimore, Md 21244 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial 2/17/2011 Arbutus, of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21. Signatur Baltimore, 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Immediate Cause (Final End-stage Alzheimers Onset and Death Dementia Physician/ disease or conditi-resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy In the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year Yes signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 \(\sum \) N 1 Tes 2 🗌 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other:
4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other} \) Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Mangrer of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural 5 Pending after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29c. License number 29d. Date signed (Month, Day, Year) Msky apamen D 20057465 2/11/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH AV. S-ZB -Baltimore, MD. 21209 2835 N. S. Rajapaksi, M.D 32. Registrar's ignatus State Registrar

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Physic Medical Exan			dle,Last) Abdi	11		El-Amin		2. Date of D Month		3. Time of Death
		4a. Facility Name (if not institut	ion, give street and nur			4b. City, Town, or L	ocation of Deat		4c. County o	
Funera		Bon Secours Hospita 5. Social Security Number		7. Age (In yrs. I	ast birthday)	Baltimore If Under 1 Year	If Under 24Hr	s. 8. Date of	Birth (MM/DD/YYYY	Birthplace (State or
Directo		213-52-1189	1√2 M 2 F	62	Yrs	Months Days	Hours Mir	_	24 48	Foreign Country) M D
any		Usual Residence of Decedent 10a. State 10b. County			Town or Locati	00		144	24 40	
. ₹	_		IA	Toc. Oity,	Balti					10d. Inside City Limits 1 XYes 2 No
or 28a-f show	recto	10e. Street and Number			Darci	10f. Zip Code			10g. Citizen of Wh	at Country?
ith the	Funeral Director	3435 Liberty		Ave	0 140 144-	212				S.A.
death w	uner	1 Never Married 2 X				s Decedent of Hisp es, specify Cuban, I			No- 14. Race White	- American Indian, Black, , etc.
11215-0036 Ide filed within 72 hours after death with the Maryland fential Hygiene, started other than "natural", or items 23a or 28a-f shoevent, the Medical Examiner must be notified at once.	by F		vorced If Yes, Give Year or Dates:			Yes 2X No			Specify:	Black
72 hour n "natu	Completed	15. Decedent's Education (Spi Elementary/Secondary (0-12			during mo	's Usual Occupation ost of working life. [16b. Kind of Bus	iness/Industry
5-0036 iled within Hygiene.	dmc	12th grade	5+		Subst Subst	itue Te	acher		Balto (Co. Schools
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle Charles Edwa	, - ,				-	_	e, Maiden Surname)	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiener 17 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (Street a	Annie and Number or F	Rural Route N	und umber, City or Town	, State, Zip Code) 21215
and 2 ealth tem 2 traum		Awatef El-Am 20a. Method of Disposition			3435	Liberty tion (Name of ceme	' Heigh	ts Av	<u>e, Balt:</u>	imore, Md City or Town, State
MOFe, Pages I and lent of Healt int: If item		1 X Burial 2 Crematio			rematory or oth	erplace) Ob ial P	ark 2/	8/201	l Wood:	lawn, Md
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Sign ture of Funeral Service	Licensee	L		ame and Address o		-,		24,117
Physician	_	23a. Fart I. Enter the disease, o	complications that dat	used the death.	430	O Wabas	h Ave.	Balt r respiratory a	imore, A	1d 21215
/Medical		failure. List only one cause Immediate Cause (Final disease								Between Onset and Death
and the second		or condition resulting in death)	Due to (or as a c	onsequence of	·):					
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence of):					
# g'A.	Exam	(Disasse or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
O, e be executed sician and burial - transit	ledical E	X UNPENDED	d	23a,27	per me	g914 4-6	6-11 vt			
760, cate be ex physician	/Med	IF FEMALE:	23c. If yes, ou	tcome of pregn				-	23d. Date of d	elivery
Box 6876 death certificate the attending phy of for use as the b	cian	23b. Was decedent pregnant in the past 12 months?	I I Live blit	h it at time of dea	ath —	al death 3 er (S <i>pecify)</i>	Ectopic pregna	ncy	Month	Day Year
. Bo; he deat y the att	Physician/M		(nown 9 Unknow					Too by		
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	þ	Part II. Other significant condit	ions contributing to a	eath but not re	suiting in the un	derlying cause give	en in Part I.	1 Ye		ute to the cause of death? Probably 4 Unknown
Records, The law require ficate has been si	ompleted							24a. Was		ere autopsy findings available or to completion of cause of
tal Reco	Com							perfe	ormed? de	ath? ✓ Yes 2 No
Vital Rec hysician: The this certificate	o Be	25. Was case referred to medica examiner?	Allegaritations	ationt 2	ER/Outpatient		Death (Check of		Residence 6	04
Division of Vital talor Attending Physician: talor Attending Physician: is after death. In Director: After this certiced in by the funeral director.		1 ✓ Yes 2 No 27. Manner of Death	28a. Date of (Month, Date)	Injury	28b. Time of Inj				how injury occurred	
ision Attend r death. ector: by the f	catio	1 X Natural 5 Pend 2 Accident Inves	stigation	flaire. At her			3 2 No		CD (C)	
DIVI	Certification:		d not be (Specify)	or injury - At nor	me, rarm, street,	factory, office build	ding, etc.	or Town,		or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:			nysician: To the best o							
To the within To the comp	Medical	29b. Signature and title of certifie	miner: On the basis of e and manner state r		d/or investigatio	29c. License n		the time, date		o to the cause(s) (Month, Day, Year)
		Pandi Fruit	hall. MI)			O.C.M.	E.		February 5, 2	1 1 1
OKKER		30. Name and address of person Pamela E. Southall, M	· ·	•		W. Baltimore S	Stroot Dalti-	nore MD 3	1222	
	ate	31. Date filed (Month, Day, Year) FEB 1 5 201		strar's Signature	е "		oneel, dailin	IOIE, MD 2	. 1243	
Regis		FFR 1 5 201	1 /2		balled					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8:43A tebruary orothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bath More City tospital Johns Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 79 Yrs Director 218-26-5240 9-13-1931 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exactings rust be notified at Director 1 Yes 2 No MD na Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 23a 21206 Funeral USA Pages 1 and 2 should be filed within 72 hours after death 5200 Bowleys Lane items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2☐No Black ģ Specify Specify: 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Sidney Ford ျှ Jennie Ruth Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43081 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Cheryl D. Jacobs-Daughter 1186 Hepplewhite Ct Westerville, Ohio 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 2-18-2011 Balto, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Soircoma Uterine **Physician** /Medical Due to (or as a consequence of) Examiner 6 MONTH Venaus Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi Hyperte Due to (of as a consequence of) Division of Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of al or Attending P safter death. I Director: After it d in by the funera 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only 29b. Signature and title of certifier 29c. License number

Registra DHMH 17 Rev 1/2001

State

Erd men

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3120

32. Registrar's Signature

les M

31. Date filed (Month, Day, Year)

FEB 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 10 855 A M Year Zai FASCETTA 2 CHRISTOPHER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 570 Kirkcaldy Way Abingdon Harford Social Security Number If Under 1 Year | If Under 24 Hrs . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 🛛 M 2 🗆 F Months Days Hours Min 04M02th Day 988 Director 141-56-1607 44 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 No Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 570 Kirkcaldy Way 21009 USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces þ Black, White, etc. 1 Never Married 2 Married rascetta ☐ Yes 2 🛛 No Christopher Fascetta Baltimore, Maryland 21215-0036 should be filed within 72 hours after If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 Divorced Specify: White "natural" Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Salvatore C. Fascetta Mary Barbara Aprile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dover NH 03820 Kevin J. Fascetta (Brother) 37 Westwood Circle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State Bayview Crematory 02-15-2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CVSZAH Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Years Hypertension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami I or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or iinjury Morkid YEURS Oberity attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ history Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed Director: After this certificate Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29d. Date signed (Month, Day, Year) D0054717 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lothery le Rameen Molavi MD Svite 200 21093 10755 Falls Rd 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

FEB 1 5 2011

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32. Registrar's Signature

11-01289

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lease	Type of Print in Black indelible ink. Ensure All Copies A	rre
	State of Maryland / Department of Health and Mental Hygis	ane

Gerald Fraley		tment of Health and Mental H ficate of Death	ygiene 2011 04261
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) GERALD WAYNE FRALEY		2. Date of Death Month Day Year February 13, 2011 3. Time of Death 1223 hrs
	4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 134-32-8301 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)New York
yland -f show any -once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland Prince George's Laure 10e. Street and Number		10d. Inside City Limits 1 Xxes 2 No
th the Maryland 23a or 28a-f sh notified at once al Director	8601 Magnolia Street	10f. Zip Code 20707	10g. Citizen of What Country? U.S.A.
s after death with t iner must be not by Funeral	11. Marital Status 1 Never Married 2 Married 2 Married Forces? 1 X Yes 2 No 3 X Widowed 4 Divorced or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:	
2 hour: "natu I Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	Sa. Decedent's Usual Occupation (Give kind of voor during most of working life. DO NOT use reting the Cork Lift Operator	
21215-0036 ould be filed within 7 americal Hygiene. A Mental Hygiene. It arrives the Medical is event, the Medical TO Be Comple	17. Father's Name (First, Middle, Last) Albert Fraley 19a. Informant's Name/Relationship (Type, Print)	Marian	(First, Middle, Maiden Surname) Leroy Rural Route Number, City or Town, State, Zip Code)
re, MD : 1 and 2 short Health and fitem 27 is or traumatic	Charlene Hutchinson / daughter 20a. Method of Disposition 20b. Place	8601 Magnolia Street De of Disposition (Name of cemetery, matory or other place)	
Baltimore, permit. Pages 1 ar Jepan 1 ar Jep	4 Donation 5 Other Specify: W • 2 21. Signature of Funeral Service Licensee	Arundel Crematory 2/1 22. Name and Address of Facility Donaldson Funeral	8/2011 Odenton, Maryland Home, P.A.
Physician /Medical :xaminer	/ M0 0 7 7 0 23a. Part I. Inter the direction of complications that caused the death. Do failure. List only one tuse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	313 Talbott Avenu	respiratory arrest, shock, or heart Approximate Interval Between Onset and
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
O, be executive sician and ounial - tra		1,27 per me g913 3-2-1	
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be h. After this certificate has been signed by the attending physicis fineral director, page 2 should be detached for use as the burion: To Be Completed by Physician/Medion: To Be Completed by Physician/Medion:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregna	ncy Month Day Year
	Part II. Other significant conditions contributing to death but not resul Cardiomegaly With Left Ventri		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown 24a. Was an 24b. Were autopsy findings available
Vital Records, ysician: The law requirements this certificate has been significator, page 2 should be Completed on Be Completed	25. Was case referred to medical	26.Place of Death (Check of	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafter death. al Director. After this certificate has been signed by led in by the funeral director, page 2 should be deach stiffication: To Be Completed by P	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER	/Outpatient 3 DOA Other Nursing	g Home 5 Residence 6 Other: 28d. Describe how injury occurred
y fill	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home (Specify)		28f, Location (Street and Number or Rural Route Number, City or Town, State)
To the Hos within 24 h To the Fun completely	(Check only 1 Certifying Physician: 16 the best of thy knowledge, to one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	or investigation, in my opinion, death occurred at 29c. License number	
	30. Name and address of person who completed cause of death (Item 23a Ana Rubio MD. Assistant Medical Examiner 900	O.C.M.E. O.Baltimore Street, Baltimore, MD	February 16, 2011
2 ift P State Registrar	31. Date filed (Month, Day Year) 7 2011 32. Registrar's Signature	harle	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month trazier 3:30 AV anthony 2011 Medical Examiner Facility Name (if not institution, give street and number) 4c. County of Death BaltiMore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** Birthplace (State or Foreign Country) Min. Months Hours Director Yrs. f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Himore 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 21201 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify 3 Widowed 4 Divorced Completed lac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, OO NQT use retired) econday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Be Eather's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Informan 's Name/Relationship 19b. Mailing Address (Stre permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of mo155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death signed by the aid be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a. Was an has page 2 autopsy performed? Yes 2 No prior to completion of cause of death? 24 hours after death.

Funeral Director: After this certificate 2 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 0 1 🗌 Yes ျှ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check within 2 To the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year H5356 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARI Carolyn Ford Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Baltimore maryland General 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF Months Hours Min Director Yrs 216-34-332 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 833 West Pratt Street 21201 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Kaydon 2th grade na Key Punch Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Palmer Ford Carrie James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Ford-Son 1653 Kirkwood Road, Baltimore, Md 21207 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 Plurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) rbutus Memorial 2/12/2011 Arbutus, Md of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner to (or as a consequence of) attending physician and for use as the burial-trans resulting in death) Last o (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe **Director:** After this certificate of in by the funeral director, page 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined hours after City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

(Check

29b. Signature a

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MD

Year),

DHMH 17 Rev 7/2009

Registrar

impleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day , Fitch February 2ď11 4:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Joseph Richey Hospice Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days August 3, Months Mary Land Director 218-42-3490 Yrs 66 Usual Residence of Deceden 28a-f shov 10b. County Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1148 W. Hamburg Street 21230 USA items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò þ 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. 10 years College (1-4 or 5+) Insulation Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Pauline O'Neil Eugene Vernon Fitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Christopher Fitch Son 1148 W. Hamburg Street, Baltimore, Maryland 21230 Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 5 cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State injury Bayview Crematory 4 Donation 5 Other (Specify) Baltimore, Maryland 14, 2011 21. Signature of Funeral Service Lic 22. Name and Address of Facility | Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Man 1401176 21222 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ CARCINOMA Due to (or a consequence of). Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transi Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death be detached signed by the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ObsTRUCTIVE Pulmonar 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Ves 2 No Division of Vital funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Tes 1 Inpatient 2 I After this ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

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Medical

29a. Certifler

only one)

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D.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEN , D.O.

32. Registrar's Signature

29b. Signature and title of certifie

CYNTHIA

31. Date filed (Month, Day, Year,

FEB 15

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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838 NORTH

BALTIMORE

29d. Date signed (Month, Day, Year) 02-12-2011

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EUTAW

MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 13, Year 2011 Physician/ 1:20 RM Donald Michael Gillotti Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h. City. Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 ► M 2 □ F Days Hours Min Month, Day Year) 1928 82 Director 219-20-9252 Connecticut Usual Residence of Decedent show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 No MD Baltimore Towson 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21204 United States 10 B Choate Ct. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, 1 ☐ Yes 2 No Specify. "natural", Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse permit. Page 1 and 2 should be filed wii Department of Health and Mental Hygie. Important: If item 27 is marked other any injury or other them. Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Albert Gillotti Mae Rumage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Gillotti /Wife 10 B Choate Ct. Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb 14 1 Burial 2 remation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Examiner ears equantially list acciditio if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Slee Duten marbid abesit Records, 1 Yes 2 No 3 Probably 4 Unknown has been si e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Plywithin 24 hours after death.
To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cortifier Fe 600 Ay 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) No Chales St. Balto, and 212010 6701 GBM(31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13, 3:15 P M February 2011 Newton Glennon Allan 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Yrs. 87 December 9, 1923 Nebraska 353-16-4610 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 United States 403 Russell Avenue #107 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 NDivorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Navy Naval Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Beatrice Bray John Roy Glennon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, D.C. 20008 4444 Connecticut Avenue, NW, #407, <u> Allan Roy Glennon / Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 15, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cotrocheartdarliese Lorda Oneweck disease or condition resulting in death) Due to fr as a consequence of) Sequentially list conditions, for the Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ✓24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy phroxilyse

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

items 23a

"natural", or

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23

permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other tra

Baltimore, Maryland 21215-0036

Examiner must

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Medical Certification:

attending physician and for use as the burial-tran as signed by the a d be detached f certificate or Attending Physician; this funeral

P.O. Box 68760

or Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was dase referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after death.

To the Funeral Director; Af
completely filled in by the fu the Hospital

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. ROBERT DIROCHBARTAND

Registra

FEB 15

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Day 20 1 1 Nellie N. Green 5:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 422 Burwood Ave. <u>Arundel</u> Burnie 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours Augus Cay, 30°, 1911 Pehris Vlvania 201-14-6566 99 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 422 Burwood Ave. 21061 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3X☐ Widowed 4 ☐ Divorced SpeciWhite Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) atal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Typist / Office/ MVA State Government 12th Be 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) မ Fred J. Schmidt Blanche F. Fairman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 422 Burwood Ave., Glen Burnie, Maryland 21061 Green TT√Son Leroy S. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State competency, crematory or other place)
tlantic Crematory, LLC Feb. 11,201 Glen Burnie, Maryland 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundamental Service Licensee 22. Name and Address of FacilityAMBROSE FUNERAL HOME, INC. alla Spring RD., Arbutus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the aid be detached for 1 Yes 2 L 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24a, Was an 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 o autonsv prior to completion of cause of death? perform Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 100 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work?
1 Yes Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature 🏚 29d. Date signed (Month, Day, Year) 2 ess of person who completed cause of death (Item 23a) (Type, Print) and add

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of State of Registrar	Maryland / Do	epartment of C <i>ertificate of</i>		Mental Hy	20	distribution of the state of th	04268
	Physici		1. Decedent's Name (First, Middle, Last) Manuela Diaz Goss		Joran Jacobs	Dour	2. Date of D	eath ary 10, 2	Year 1	3. Time of Death 7:53 P M
	Medi Exami		4a. Facility Name (if not institution, give street and number Upper Chesapeake Medica	•		or Location of Dea		4c. County		
	Funeral Director		5. Social Security Number	Age (In yrs. last birthd 80 Yr	Months Days			rth 1, Year 1931	g. Birthp Puer	lace (State or Foreign
	Aaryland 8a-f show tified at	Director	10a. State 10b. County MD Harford	10c. City, Town o	Bel Air				10	Od. Inside City Limits
	with the last 23a or 2	Funeral Di	10e. Street and Number 1307A Scottsdale Drive		10f. Zip Code	21015		10g. Citizen of V United		
9200	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dates	No No	13. Was Decedent of If Yes, specify Cul		Specify Yes or No rto Rican, etc.)	Diao	e - America k, White, e Puer	
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "nat er the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 of 4)	(G	ecedent's Usual Occu Bive kind of work done ie. DO NOT use retired Nurse	during most of w	orking	16b. Kind of Bu	isiness Indi	•
yland	ald be filed Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last) Ramon Diaz				ame (First, Middle on Rosar:	Maiden Surname 10)	
e, Mar	and 2 shou Health and em 27 is n		19a. Informant's Name/Relationship (Type, Print) Gwen Brown - Daughter		Mailing Address (Stree	t and Number or F	ural Route Numbe Bel Ai	er, City or Town, Sir, MD 210	tate, Zip Co	ode)
timor	it. Page 1 artment of hertant; If ite		20a. Method of Disposition 1	te Glement Memor	isposition (Name of crematory or other plants Park		Date 15-2011	20c. Location - Glen Bu	ırnie	, MD
Ba	permi Depar Impor any in		Signature of Fune al Service Ucensee 23a. Part 1. Enter the disease, or complications that cause of the service 20/	22. Name and Addr	hur Spri	ng Rd.,	Arbutus,			
	hysician/ Medical Examiner		Immediate Cause (Final disease or condition	ine. PSFD as a consequence of):	NG WITH					Approximate Interval Between Onset and Death
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. Box 687	To the Prospital or Attending Physician: The law requires that the death certificate be executed within 24 hours death. To the Funeral Director, 48 ther this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Physician/Me	IF FEMALE: 23c. If yes, outcome 1	h 2 Fetal death t at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify) _	су		23d. Date Mon	e of deliver	y Day Year
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vision	or Attendii Iter death. Irector: At n by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of li	njury - At home, farm, etc. (Specify)	M 1 🗆	Yes 2 No	28f. Location (S City or Tow	itreet and Number	or Rural R	oute Number,
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	Io the within To the comple		only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	e best of my knowledg	ge, death occurred at the	e time, date and pl	ace, and due to the	e cause(s) and man 29d. Date signed	ner as state	ed.
	15		30. Name and address of person who completed cause of	MD death (Item 23a) (Time	D4.	5344		02/1	1/20	//
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			1 - State of Maryland / Department of Health and M Certificate of Death	, 0	ene . No 1111	11,269
	Physic	ian		Date of Death Month	Day Year	3. Time of Death
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2			Wilson Helath Care Center Gaithersburg		Monto	gomery
ı	Funeral Director		5. Social Security Number 032–14–9913 6. Sex 1	8. Date of Birth (Month, Day) 08/21/19	9. Bi	rthplace (State or Foreign ountry) MA
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, The "sectoal Exercited in that the notified at	by Fune	If Yes, Give 1 □Yes 2√7 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, White	
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altin	교본변경 .		4 Donation 5 Other (Specify) Final Journey crem . 2/17/ 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Eacility	′2011 W	oodbine,	MD
m	Depa Impo any is	() (Dowley land Maryland Crem.	Baltimo	re, MD2	1203
	Physician	62 A	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final	r respiratory arrest	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Advance of demonstration			One month
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89 X	D 60		IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome of pregnancy			
P.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attending director, page 2 should be detached for use in	Physician/N	23b. Was decedent pregnant in the past 12 mofiths? 1		23d. Date of de Month	livery Day Year
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Records,	w requi	leted	Asthmatic bronchetis			obably 4 🗌 Unknown
al Re	sician: The lav certificate has rector, page 2 a	Completed by		24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 □ No
Vital	nysician: nis certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No			
Division of	ding Phys h. After this funeral di	Ion: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work?	8d. Describe how i	e 6 ☐ Other (Spe injury occurred	city)
NSIC	Attend r death ector: by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stree	t and Number or Ru	ural Route Number
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
i	To the within 2 To the complet	≥	29b. Signature and title of certifier 29c. License number 04115		Date signed (Monti	
,		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/00/00/00/00/00/00/00/00/00/00/00/00/0	12/11	mary!	7,2011
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL ACH MA CALTHER SULL 31. Date filed (Month, Day, Year) 32. Registrar's Signature	26, ms	20844	1
	Stat Registra	e ır	31. Date filed (Month, Day, Year) FEB 15 2011 32. Registrar's Signature Secretary Se			

DHMH 17 Rev 1/2001

11-01119 Alfred Granato Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Alfred Granato		State of Maryla I-For State Registrar		rtment of tificate of		and M	ental H		2 () a	1 14270
Physiciai Medical Examin		1. Decedent's Name (First, Middle,Last) Alfr	ed Gr	anato				2. Date of Dea Month February	Day Year	3. Time of Death 1202 hrs
		4a. Facility Name (if not institution, give street and num Union Hospital	iber)	4	4b. City, Town	n, or Locati	on of Deatl		4c. County of D	eath
Funeral Director		146-78-2790 1XM 2 F	7. Age (In yrs. Ia 39	st birthday) Yrs.	If Under 1 Months	-	Jnder 24Hrs ours Mir		100	Birthplace (State or preign Country) NJ
an y		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on					10d. Inside City Limits
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h the Mary 3a or 28a- otified at	I Director	10e. Street and Number 534 Broad Street #8			10f. Zip Coo 2	1903		11	og. Citizen of What (USA	Country?
	Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	dent Ever in U.S ces? 2 X No	If Ye	s Decedent or es, specify Cu	ıban, Mexi	can, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Ar White, et Specify: W	
nours af	8 8	15. Decedent's Education (Specify only highest grade		16a, Decedent		upation (Gi	ive kind of	work done	16b. Kind of Busine	
1036 rithin 72 F ene, er than "1, redical F	Completed	Elementary/Secondary (0-12) College (1~	or 5+)	_	uck Dr		or useren	iiod)	Food	
21215-0036 Mental Hygiene Tevent, the Medica	Re	17. Father's Name (First, Middle, Last) Alfred R. Granato Sr.					Eva	DeVito	Maiden Surname)	
MD 2. d 2 shoulk th and M n 27 is m ummatic	2	19a. Informant's Name/Relationship (Type, Print) Eva Granato / Mother							nber, City or Town, Sie Beach, S	
Baltimore, MD 21215-0 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygin Important: If them 27 is marked oth injury or other traumatic event, the I		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	n State Cr	lace of Dispositematory or oth	er place)	•	1	Date 6/2011	20c. Location - City Woodbine	
Baltimore, pemit. Pages 1 a Department of He. Important: If He injury or other tr	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Donota							Service more, MI	•
Physician /Medical Examiner		23a. 「arr1. Enter the disease, or complications that cau failure. List only one cause on each line. Ind Immediate Cause (Final disease a. Cardio	sed the death. [luenza vascula:	Do not enter the Compli r Disea	e mode of dy Cating	ing, such a	s cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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50, tte be ex hysician burial	Medical	TAMENDED AMENDED FEMALE: 23c. If yes, ou	23a,27		g914	4-6-1	ll vt		Local Data of delli	
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P.O. Ess that the d	2	Part II. Other significant conditions contributing to c	eath but not res	sulting in the ur	nderlying caus	se given in	Part I.			to the cause of death?
cords, law requir has been si 2 should the	ourbiered							24a. Was a autops perform	sy prior t med? death	
Vital Rec ysician: The his certificate director, page		5. Was case referred to medical examiner?				ace of Dea	th (Check o	peeg		
ion of Vi tending Phys eath. for: After this the funeral di	- 1-	1 ✓ Yes 2 No 1 ✓ Inp. 7. Manner of Death 1 ✓ Natural 5 Pending		R/Outpatient 28b. Time of Inj	jury 28c. I	njury at Wo	ork?	g Home 5 F	Residence 6 Ot	her:
Division or applied or Attending tours after death, neral Director: After filled in by the fune Certification.	e I III Ca	4 Homicide Homicide Could not be determined (Specify)	of Injury - At hom	ne, farm, street				28f. Location (S or Town, St		Rural Route Number, City
To the Hosp within 24 ho To the Func completely functional conficient	11.0	9a. Certifier 1 Certifying Physician: To the best of me) 2 Medical Examiner: On the basis of and manner states	examination and							
F * F 8	1	9b. Signature and title of certifier			- 1	ense numb	er		29d. Date signed (M	
sk		Family Twithell, ML) 0. Name and dress of person who completed cause			0.	C.M.E.			February 10, 2	U11
8		Pamela E. Southall, MD Assistant M			W. Baltim	ore Stre	et, Baltir	more, MD 21	223	
Stat Registra	e :	1. Date filed (Month, Day, Year) 32. Regin	strar's Signature	1 Som	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02-03-201 T Steven David Hisley 222 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Months Days Hours 1**X**□ M 2 □ F 05-073-2 521 Director 217-38-8137 69 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt. If item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 West 39th St #304 21204 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Project Manager Consulting Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Calvin K. Hisley Ida Breen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Hisley (Brother) 3605 My Ladys View Ct Monkton, MD 21111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of I-Important: If ite any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation Den (Specify) Bayview Crematory 02-04-2011 Baltimore, MD 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir \mathcal{Q}_{-} MacPhail Rd BelAir, MD 21014 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ HRONIC MYQLOGONOUS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Dualto (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation Accident 1 🗌 Yes 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of cer cause of death (Item 23a) (Type, Print)

10.

State Regist<u>rar</u>

DHMH 17 Rev 7/2009

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 13 Month 8:45 PM M BETTY ANN HOPKINS 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death HARFORD UPPER CHEASPEAKE MEDICAL CENTER BEL AIR Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🔀 F July 7, ^{Ye}1/931 New York 79 **Director** 212-28-3802 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No Maryland Harford Abingdon 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 2812 Emmorton Road 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Construction Company Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Eleanor Chivers William James Harney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Webster Lamar Hopkins / Husband|2812 Emmorton Road, Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or Rock Run U.M. Chr. Cem 2-18-11 Havre de Grace, MD 4 Denation 5 D re of Funer MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland any 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 0 UNKROWN Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes or Attending Physician; 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 (No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 10⊒ Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital within 24 hours.

To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) Ugu me who completed cause of death (Item 23a) (Type, Print) LOH 31. Date flad (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph E. 201^{rga} Hennegan February 8:15 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson **Baltimore** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Hours Min. Sept 8 Months 214-22-6807 Year 927 Mary Land 83 Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Lutherville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1524 Norman Ave. 21093 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.M.C. Retired_Lt. Colonel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Η. Hennegan Henrietta Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Susan McGinley / Daughter 1524 Norman Ave. Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corporation 2/15/2011 4 Donation 5 Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 YorkRoad Towson, Maryland 21204 23a. Part 1. Enter the disease, arcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performed? Yes 2 Dialo certificate 1 Yes 2 No 25. Was case referred to medical Be la 26. Place of Death (Check only one) examiner? 2 No 1 Tyes Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural □ Accident 5 Pending iniury work? Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours at To the Funeral D completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign nd title of certifier License number 2011 6701 31. Date filed (Month, FEB 15

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** - Month Year 4: 48 PM Anna Rose Hines rebruary 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Arnold Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) 10/9/1929 9. Birthplace (State or Foreign **Funeral** 1 □ M XX F Days Hours Min. Months 214-24-4297 81 Maryland Director Usual Residence of Decedent death with the Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 □Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 Bliss Lane Funeral 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ XX Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, it will $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Data Processing State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John ပ Brownley Catherine Hoffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once. Mr. Larry Hines / Son 68 Wishing Rock Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation MXOther (Specify) Entombment Cedar Hill Cemetery 2/16/2011 Brooklyn, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation N101220 FIE Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** caranson ancreal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☑No ned by the a detached f 9 Unknow cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? e Hospital or Attending Physician: The 24 hours after death.
e Funeral Director: After this certificate ha 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier EcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29b. Signature and title of certifier 29c. License number 57531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Musi 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Montal Liveing

			for State		State of N	viaryiar		artment of			lental Hy	giene		
			Registrar 1. Decedent's I	Name (First, Middle, I	Last)		Cei	tificate of	Deatr	7		Reg. No	UII	U4213
ı	Physic Med		/ / /	verno	Hi	cks	•				2. Date of Dea	ath Pay	2011	3. Time of Death
	Exam		4a. Facility Nam		ive street and number)			4b. City, Town,	or Locatio	n of Death	<u> </u>		ounty of Death	2:55PM
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1	Funera Directo			6-9328	. Sex 1 □ M 2 🔀 F	ge (In yrs. I 86	last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birt	h (Year)	9. Birthi	place (State or Foreign
	, wo		Usual Residenc	e of Decedent		- 00	115.				06/03/	1924	Court	PA PA
	ryland -f sho	cto	10a. State	10b. County		10c. Cit	y, Town or Loc	ation					1	0d. Inside City Limits
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36	after o	è	1 Never M	larried 2 Married	1 163 2 4		"	Yes, specify Cub	an, Mexica	an, Puerto F	Rican, etc.)	14.	Race - Americ Black, White, e	
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m	Page nent o int: If	١.	1 🛣 Burial 4 □ Donatio	2 Cremation 3 on 5 Other (Spec	Removal from State	ce	emetery, crema	tory or other plac		Da	- 1		on - City or Tov	
Baltimore,	permit. Page 1 Department of Important: If i any injury or o			uneral Service Licer		Mea	aowria	ge Mem. Name and Addres	PK.		2011 2nd Ave	E1k:		Maryland
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ŏ	eath certific attending I for use as	cian	23b. Was deceder in the past 12	months?	23c. If yes, outcome of	2 🔲 Fetal o	death 3 🗌 E	ctopic pregnancy	,				Date of delivery	
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<u>a</u>	certifi rector	m i	25. Was case reference examiner?		Hospital:			26. Plac	e of Deat	h (Check on		Z No	1 Yes 2	□ No
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DIVISION	ter de recto		3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury	/ - At home			#S Z []		Location (Stree	at and Num	har as Result Re	
בֿ בֿ	urs af				building, etc.	(Specify)				201.	City or Town, S	State)	ber or Hurai Ho	ute Number,
100	within 24 hours after death, To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2	Certifying Phys	ician: To the best of m ner: On the basis of exa e Practioner: To the be	y knowledo	ge, death occu	red at the time, o	ate and pl	lace, and du	ie to the cause(s) and man	ner as stated.	
7	Nithin Fo the	_	only one) 3 9b. Signature and		e Practioner: To the be	est of my kn	owledge, death		into, dato c	and place, ar	id due to the cal	use(s) and n	nanner as stated	1.
				/(/	1/1_		MD	29c. License n	umber 5 6 フ_	25	29d	Date signe	ed (Month, Day,	
		3	0. Name and addre	ess of person who co	ompleted cause of dea	th (Item 23:	a) (Type, Print)	1	- /6		~~~~	- /		2011
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	State Registrar		FEB 15	7, Day, Year)	32 Registrar's	Signature	11			1		- 4		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤉 🦳 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 10:30p^M 2011 02 0 Lonnie W Howie Sr. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Howard County General Columbia Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) Country 1**X**□M 2 □ F 04 39 MD Director 07 212**-**34-8866 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f shov 10a. State items 23a or 28a-f sho ner must be notified at Director 1 🗌 Yes 2 🗶 No MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21043 5348 Kerger Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2x No Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Analyst 12th grade 2yrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ <u>Mary E. Blackman</u> Willie C. Howie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 348 Kerger Road, Ellicott City, Md 21043 Alba Howie-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State Garrison Forest Vet 2/18/2011 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer March F/H West Baltimore Md 21215 non rume 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DECUBITUS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury LUNG CARCINOMA attending physician and for use as the burial-transit METAS TATIC that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 Other (specify) 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv has performed? Yes 2 No death? page 1 Yes 2 No certificate After this certification, I 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Npatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Manner of Death Certificate: 1 Natural 2 Accident 5 Pending Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 2 ☐ Accider
3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

State

death.

Medical

4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person wh

determined

PATEL

Hospital or Attending Physician: The law requires that the death certificate be exec

Division of Vital Records, P.O. Box 68760

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Registrar

eted cause of death (Item 23a) (Type, Print)

little

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1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 50404

29c. License number

City or Town, State)

Patuxent Parkway Switc 111, Columbia, MD 21044

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **09** Physician/ 02 2011 30p Henderson Medical MOSES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Manor Care Nursing Home</u> If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Country) X M 2 □ F Director 74 224-44-2573 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 21215 4030 Annellen Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates. event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Industry Fisherman <u>2th grade</u> na and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frazier Parks Aurelius Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21215 Annellen Road, Baltimore, Sherryl Gray-Daughter
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) s Family 2/ 22. Name and Address of Facility March F/H West 2/15/2011 Kilmarnock. 21. Signatur of Emeral Service Li al 21215 300 Wabash Ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4054 Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Ordenning Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death? 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical 26. Place of Death (C_ck only one) Be examiner? Hospital 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death. Director; After this 27. Manne f Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D0069314 MD

Registrar
DHMH 17 Rev 7/2009

State

Mittal

31. Date filed (Month, Day, Year)

8813

32. Registrar's Signature

Walthom

Woods Rd

Parkville MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Physician/ HAYASHI 12:12 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DRIVE Montgomery ILVER 50 MING Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 🗆 F 91 Hours (Month, Day, Year) 19 532-44-2376 Japan Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at anone. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Silver Spring MD Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA Funeral 12506 White Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: If Yes, Give Specify: Asian Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Trade Negotiator Be 18. Mother's Name (First, Middle, Maiden Surname) Nao Hayashi 17. Father's Name (First, Middle, Last) ပ Ryozo Hayashi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Gilbert/Daughter 12506 White Drive, Silver Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2XX remation 3 ☐ Removal from State Final Journey Crem. 2/17/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility
Maryland Cremation
PO Box 1413, Baltis Services MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final EMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 1 No 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No DANGHTERS 25. Was case referred to medical 26. Place of Death (Check only one) Be RESCOENCE examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 2 **X** No 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the burial Division of Vital Records, P.O. Box 68760 signed by the a should b cate has page 2 s r this certificate haral director, page in 24 hours area. he Funeral Director. Afterwated filled in by the fur

Baltimore, Maryland 21215-0036

Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 2011

State Registrar

Medical

PATE 31. Date filed (Month, Day, Year) FEB 15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Ave. #103, 1812 GEORGIA Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:50PM 201 Medical 4b. City, Town, or Location of Death 4c. County of Death Name (if not institution, give street and numbe Examiner N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days December 4, 1921 Roccestoro. MD. 1 □ M 2 □ F Months Hours Min. 89 Director 212-14-8043 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified Baltimore N/A 1 X Yes 2 No Maryland 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 21224 611 Umbra Street ural", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 Widowed 4 Divorced Completed Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lithographer Printing 8 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary E. Cline Robert A. Hines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) of Health a 611 Umbra Street, Baltimore, Maryland wife Josephine Hines t: If item 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of February 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Important: If any injury or once. Boonsboro Cemetery Boonsboro, Maryland 16, 2011 onature of Fundal Service Licensee Connelly Funeral Home of Dundalk, P.A. nero 7110 Sollers Point Road, Dundalk, Md. complications that caused the death \mathscr{B} o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine il any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: Te law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed ge 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform has death?

1 Yes 2 No certifica e Yes ä director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 \square Pending 1 Yes 2 No death. Accident Investigation after deatl 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Tyestical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ly one) 29d, Date signed (Month, Day, Year) 29b. Six title of Boulevard, Baltimore MD 21218 ed (Month, Day, State 5 2011

DHMH 17 Rev 7/2009

Registrar

11-01186	
Denny Jones	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Denny Jones		St 1- For State Registrar	ate of Maryl		artment o ertificate o		d Mental F		2 () Reg. No.	1, 04280
Physicia	n/	Decedent's Name (First, Midd	le,Last)		·			2. Date of De	ath	3. Time of Death 1420 hrs
Medical Examin	er	Denny 4a. Facility Name (if not institution	Lee	JO umber)	nes	4b. City, Town, or	Location of Deat		Day Year 11, 2011 4c. County of	
		338 Grovethom Road				Middle Rive			Baltimore	
Funeral		5. Social Security Number	6. Se x	7. Age (In yrs.	last birthday)	If Under 1 Year		_		Birthplace (State or Foreign
Director		216 92 9939	1 X M 2 F	33	Yrs	Months Days	s Hours Min	8/10/		Country) Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Locat	ion				10d. Inside City Limits
È	١	Maryland Balt	imore	Mid	dle Riv	or				1 Yes 2 X No
ne Maryland or 28a-f show fied at ouce.	Director	10e. Street and Number	THOLE	1 MIC	are Kry	10f. Zip Code			10g. Citizen of Wha	at Country?
ith the ? 23s or notifie	ﻕ	336 Grovethorn				21221			U.S.A.	
ath wi	Funeral	11. Marital Status 1 Never Married 2 MM	arried Armed F			as Decedent of His es, specify Cuban			o- 14. Race - White,	American Indian, Black, etc.
fter de		3 Widowed 4 Div	1 Yes rorced If Yes, Give Ye or Dates:	2 X No ar	1	Yes 2 X No	specify:		Specify: T	White
136 thin 72 hours aftered the "battural", than "battural", edical Examiner	ed by	15. Decedent's Education (Spe	cify only highest gra			nt's Usual Occupati			16b. Kind of Busi	
36 in 72 l	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)						
d with	튅	12 17. Father's Name (First, Middle,	, Last)		Manage		18. Mother's Nam	e (First, Middle,	Restaur Maiden Surname)	ant
be file	8	Thomas Bri	an Jo	nes			Robin	Lynn		nolds
D 2's should and Me matic entrice	의	19a. Informant's Name/Relations	(Wife)	î.				mber, City or Town,	
MOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mantal Hygiene. ant: If item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at once.	ŀ	Angelia Susann 20a. Method of Disposition	e Yard —		Place of Dispos	Grovethon Sition (Name of cen		Middle Date	20c. Location - C	Maryland 21220 Dity or Town, State
MOF6	ы	1 Burial 2 X Cremation			crematory or ot		2	616	Paltimo	ore, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medican	ŀ	4 Donation 5 Other Sp 20 Signature of Funeral Service] Da	22. N	rematory lame and Address	of Facility			
	4	John W. Ku	rkowske	/	B	ruzdzins) 407 old	ki Funer Eastern	al Home Avenue	Essex. M	Maryland 21221
Physician Medical	4	23a. Part I. Enter the disease, or failure. List only one cause	on each line.	caused the death	n. Do not enter t	ne mode of dying,	such as cardiac	or respiratory ar	rest, shock, or hear	t Approximate Interval Between Onset and Death
xaminer	1	Immediate Cause (Final disease or condition resulting in death)		a consequence (of):					Deali
		Sequentially list conditions,	b							
	흹	if any, leading to immediate cause. Enter Underlying Cause	c.	a consequence o	of):					
ist e 0	Examiner	events resulting in death) Last	Due to (or as	a consequence o	of):					
S0, te be executed to be executed by sician and the barrier of the sound the	edica	UNPENDED	M AMENDED	4a per	me g913	3-7-11	vt		****	
760 ficate b g physi- the bu		IF FEMALE: 3b. Was decedent pregnant in th		outcome of preg					23d. Date of d	
cords, P.O. Box 6876 law requires that the death certificate that been signed by the attending phy 2 should be deached for use as the learners.	Physician/M	past 12 months?	4 Pregi	oirtn nant at time of de	a oth	tal death 3 L her <i>(Specify)</i>	Ectopic pregn	ancy	Month	Day Year
Bo ne deat the at	lys.		9 Unkn					Too. p: u		(1.00
P.O. s that the med by e detach	ক্র	Part II. Other significant condit	ions contributing t	o death but not i	resulting in the u	ınderlying cause gi	iven in Part I.			ute to the cause of death? Probably 4 Unknown
ds, equire	Completed							24a. Was		ere autopsy findings available
e law re has t	Ē								ormed? de	or to completion of cause of ath? Yes 2 No
n: The ruifical tor, pa		25. Was case referred to medical				26.Place	of Death (Check		2 140	Yes 2 No
Vita hysicia this ce all direc	80	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other Nursi	ng Home 5	Residence 6	Other: Scene
Division of Vital Records, P.O. rate or attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ation:	Manner of Death Natural 5 Pend Accident Invest	fing 28a Date FOUND FOUND Feb 11,	n, Day,Year)	28b. Time of I FOUND: 1415 hrs		y at Work? ′es 2. ✔ No	28d. Describe Subject hai	how injury occurred nged self	d
Divis	Certification:	3 ✓ Suicide 6 Coul	d not be 28e. Plac	e of Injury - At h Single Far		et, factory, office bu	uilding, etc.		(Street and Number State) om Road, Middle	or Rural Route Number, City River, MD
	Medical	(one on only	nysician: To the be miner:On the basis and manner:	of examination a						
H 3 H 8	ž	29b. Signature and title of certifie		1 ^	-	29c. License				(Month, Day, Year)
		MICI		121)		O.C.N	VI. ⊑.		February 12	, 2011
10		30. Áame and address of person Russell Alexander MD		se of death (Iten / ledical Exar	•	W. Baltimore	Street, Baltir	nore, MD 21	1223	
Sta	te	31. Date filed (Month, Day, Year) FEB 1 5 2	011 82. R	egistrar's Signat	wre park	1				
Registr	EL I	1 5 0 5 0 6	UII (MAC)	La.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2011 <u>A</u> M Madalyn R. Jones February 3:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing & Rehab. Center Prince George's Laurel Social Security Number 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min (Month, Day, lay 24, Director 89 214-12-7566 Maryland May Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 No Prince George's Laurel 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 824 8th Street, Apt. 104 20707 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: White "natural", Specify: 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Department of life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture 7th Lab Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carson B. Eubanks Lottie E. Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna D. Ludwig/Sister Laurel Mayfair Drive, __MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2/17/2011 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one does on each line. 23a. Park Approximate Interval Between Onset and Death

Weels Immediate Cause (Final Cardiovascular Ph sician/ Accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Examir the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Month Dav signed by the a 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No nis certificate has b I director, page 2 sh 24a. Was an autopsy performed Yes 2X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 【▼ No Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1XXNatural injury 5 Pending Accident
Suicide 1 Yes 2 No Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month. Day. Year)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

14333 Laurel Bowie Road, Suite 208, Laurel, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadiq, M.D.

31. Date filed (Month, Day, Year)

15

FEB

February 15, 2011

20708

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Dep	artment of Health and M rtificate of Death	
			1. Decedent's Name (First, Middle, Last)	tillcate of Death	Reg. No. 2. Date of Death 3. Time of Death
	Physici /Medic	al	Devon 4a. Facility Name (If not institution, give street and number)	ag ler 4d. City, Town, or Location of Death	February O 2011 3:55 AM 4c. County of Death
	Examin	er	The Johns Hopkins Hospital	Baltimore City	N/A
	Funeral Director	1	5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) 1 1 M 2 X F 1 9 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MAY 17,1991 MASSACHUSETT
			Usual Residence of Decedent 10a State		10d. Inside City Limits
	laryland f show d at	ō			1 → Yes 2 □ No
	r 28a-	Director	MD N/A BALT 10e. Street and Number	IMORE 10f. Zip-Code	10g. Citizen of What Country?
	th with 23a o st be		512 S. BETHEL STREET	21231	U.S.A.
36	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	necify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	nin 72 hour n "natural" Aedical Ex	Completed I	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	
212	filed withi Hygiene. other than ent, the M	E O	1	STUDENT	N/A ne (First, Middle, Maiden Surname)
gug	tal d c	Be	17. Father's Name (First, Middle, Last) KARL JAGLER	DIANE	
Maryland	and 2 should be i eath and Mental I n 27 is marked of ier traumatic evel	၉			ral Route Number, City or Town, State, Zip Code)
	and 2 sath ar 27 is er trau		DIANE JAGLER/ MOTHER 512	S. BETHEL STREE	ET, BALTIMORE, MD 21231
Baltimore,	Pages 1 nent of H int: If iter iry or oth		4 Donation 5 Other (Specify) BAYVIET	ornatory or other place) N CREMATORY 2/1	Date 20c. Location - City or Town, State 1/2011 BALTIMORE, MARYLAN
Balti	permit. Departn Importa any inju		21. Signature of Funeral Repvice Licensee	22 Name and Address of Facility LILLY & ZEILER 1901 EASTERN AV	INC. FUNERAL HOME ENUE, BALTIMORE, MD 21231
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		Onset and Death
	/Medical Examiner		resulting in death) Du to (or as a consequence of):		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury)		
b.	cuted nd transit	Examine	that initiated events C		
), O	be executed sician and burial-transit	al E	resulting in death) Last Due to (or as a consequence of):		
,0928	physical phy	ledical	d		
). Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
ds, P.O.	requires that the de been signed by the a should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Records,	The law requ e has been vage 2 shou	Completed			24a. Was an autopsy performed? 1 ✓ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
of Vital		Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check anly one)
o	Physic this ce ral dire	욘	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 2 ☐ ER/O	ent 3 DOA 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
on	ding Phy th. After this funeral	tion	1 ✓ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation		
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital within 24 hours a To the Funeral C completely filled	edical C	29a. Certifier (check off 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number RES - 000	29d. Date signed (Month, Day, Year) February 9 2011
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	North Wolfe St, Baltimore, MD, 2128
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Regist	rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year)		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Time of Death

The American Market Strategy of the American Ma 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FLOVUAV DOROTHY JEAN KNIGHTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** KENTUCKY Hours Min. 04/16/1940 Months Director 217-38-2156 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is nanked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes av ☐ No MD. ANNE ARUNDEL SEVERN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8218 ATHENA LANE 21144 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 K No Specify: WHITE Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH O MACHINE OPERATOR HARLAND CHECKS Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES ANDERSON BOBBIE McVEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID KNIGHTON/SON 8218 ATHENA LANE, SEVERN, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 02/12/2011 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, 6224 EASTERN AVE., BALATIMORE, MARYLAND 23a. Part . Enter the dise se r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 15245 Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Many er of Death Certificate: 28c. Injury at work?
1 Yes 2 No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 2011 30. Name and address of person who 1213 31. Date filed (Month, Day, Year) FEB 1 5 2011 State Registrar

DHMH 17 Rev 7/2009

KNIG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day / 2011 4:45AM FERRUNA Physician/ S. UTH 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Reisterstown Cherrywood Nursing Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Mary land Min. Months Days Hours **Funeral** 1 M 2XXF Nov. Yrs. 100 215-10-1955 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 1 🗌 Yes 2XXNo Director Lutherville **Baltimore** Maryland 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number of America Funeral 21093 11636 Greenspring Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **2XX** No If Yes, Give Year or Dates. be filed within 72 hours after death Black, White, etc 11. Marital Status 1 Never Married 2 Married Completed by 1 Yes XX No Specify: Specify: White 3XXWidowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Retail Buyer 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Adella Queen Harris 2 Alfred Besse Smith permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12311 Dover Road, Reisterstown, MD 21136 Vance D. Kopp, Jr. (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Feb. 16, 20a. Method of Disposition Carrolle Cemetery 1 XX Burial 2 Cremation 3 Removal from State Lutherville, MD 2011 4 Donation 5 TO Othe (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel, 21. Signature of Funeral 11605 Reisterstown Rd., Owings Mills, MD 21117 Rad. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FAILURE TO THRIVE Immediate Cause (Final disease or condition Physician/ Due to (or as a consequence of) Medical resulting in death) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical pe 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Fctopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ned by the atter detached for u Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be

Box 68760 Hospital or Attending Physiclan: The law requires that the death certificate I 24 hours after death. Funeral Director: After this certificate has been signed by the attending phys Records, Division of Vital

Baltimore, Maryland 21215-0036

Other: examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

29c. License number 29b. Signature and title of certifier ROSSES2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Purnue #203 BANTHORE, MANY/AND 21209 Smint PSHUESNC. DIAMONS 2835 32. Regi rar's Signature

State Registrar

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Certificate:

Medical

Suicide

6 Could not be

e Funeral I

Fo the within?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner 100 8. Date of Birth (Month, Day, June 8, If Under 9. Birthplace (State or Foreign Funeral Social Security Number Age (In vrs. last birthday) 1 □ M 2 🙀 F Hours Min Mary Land 1929 81 Director 213-28-8057 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1108 W. 43rd Street 21211 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black White etc. 1 Never Married 2 W Married ģ 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Corporate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Lawrence Ward Mildred Gettle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 W. 43rd Street Baltimore, Maryland 21211 19a. Informant's Name/Relationship (Type, Print) Dean I. Krebs Husband Important: If item 2 any injury or other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Department of 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 2/17/2011 Parkville, Maryland 21. Signature uneral Service L 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentially list conditions: Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown been signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? **Division of Vital** the funeral director. 26. Place of Death (Check only one) Be 2 Hospital ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kos erson who completed cause of death (Item 23a) (Type, Print) Name and address of 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

n/ al	State Registrar 1. Decedent's Name (First, Middle)	e, <i>Last)</i>			Cer	tificate of	Death		2. Date of Dea	Reg. N	lo. (_ U	3. Time	of Death
	PATRICIA MARY KRI	EGER							Month FEBRUAR		⁾ ay 2011 Yea		A M
	4a. Facility Name (if not institution	, give street a	nd number)			4b. City, Town,		of Death	•	4	c. County of De	eath	
	LIGHTHOUSE SENIOR 5. Social Security Number	LIVING 6. Sex	7 1	un America In	nt birthday)	ELLICOTT If Under 1 Year		2/ Hrs	8. Date of Birt	h	HOWARD	Disth-lass (Ctato	or Foreign
	216.34.7419	1 M 2	¬xx / / /	71	st birthday) Yrs.	Months Days		Min.	(Month, Day	, Year) 193	9.5	Birthplace (State Country) MD	or r or eight
- h	Usual Residence of Decedent 10a. State 10b. County			10c City	. Town or Loc	eation						10d. Inside (City Limits
Director	MD HOWA	RD			T FRIEN								s 2 XNo
	10e. Street and Number			I III	1 1100	10f. Zip Code				10g. C	Citizen of What	Country?	
	2661 WELLWORTH WA	-			lie e	217			77.12		USA		
by rulleral	11. Marital Status1 ☐ Never Married 2 ☐ Mar	Arr	s Decedent ned Forces? Yes 2xx			Vas Decedent of I Yes, specify Cub					14. Race - Ar Black, Wh	merican Indian, hite, etc.	
	3xx Widowed 4 □ Divorced		es, Give AX ar or Dates.		1	Yes 2 No	o Specify:				Specify: Wi	HITE	
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	17. Father's Name (First, Middle,	Last)					18. Moth	er's Nam	e (First, Middle,	Maidei	n Surname)		
의	HARRY POLK					-	1		ISHER				
	19a. Informant's Name/Relations PAM FRISCHKORN	nip (<i>lyp</i> e, <i>Pnn</i>	DAUGHT	FR		g Address (Street VELLWORTH						Zip Code)	
ı	20a. Method of Disposition			20b. Pl	ace of Dispo	sition (Name of natory or other pla			Date		Location - City	or Town, State	
	1XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (8	3 ☐ Remov Specify)	al from State			CEMETERY		.11.2	2011	BAL	TIMORE, M	1D	
	21. Signature of Funeral Service		h		F	Name and Addr NK FUNERA	ess of Facilit	P.A.	alaca er				
	23a. Part 1. Enter the disease, of	1		01148 d the death		r the mode of dvi				_	061	Approxim	ate
	shock, or heart failure. List of Immediate Cause (Final	only one cause		e. VER CAI	NCER							Interval Bo Onset and	etween
1	disease or condition resulting in death)	a	Due to (or as	a consequ	ence of):							1	
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_	that initiated events resulting in death) Last	С	Due to (or as	a consequ	ence of):								
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	in the past 12 months? 1 Yes 2 XX No	4 [⊒ Live Birth ⊒ Pregnant a ⊒ Unknown			Ectopic pregnar Other (specify)	icy				Month	Day	Year
	9 Unknown			out not resu	ulting in the u	nderlying cause g	iven in Part	l.	23e Did to	hacco	use contribute	to the cause of	death?
	Part II. Other significant condition		J		5	, 0						Probably 4	
3	Part II. Other significant condition										0.41- 18/2	autopsy findings	
5	Part II. Other significant condition								24a. Was			to completion of	
١	Part II. Other significant condition								autop perfo	rmed?	prior t death	to completion of ? Yes 2 \(\sigma\) No	cause of
pe completed by	25. Was case referred to medical examiner?	Hospita	i:				Place of Dea		autop perfo 1 🗆 Yes k only one)	rmed?	prior t death No 1 🗆 V	? Yes 2 □ No	
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DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16:35 M Elizabeth 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 213-36-6956 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** JAN25, 1938 MARYLAND 1 □ M 2 X F Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location show at 1X Yes 2 □ No r 28a-f sh notified MD. Director BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō must be 2903 EASTERN AVENUE 21224 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes X☐ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic ever once, JOHN NODOLNY ANNA SISOLAK မ 19a. Informant's Name/Relationship (*Type. Prin(*HUSBAND) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEOPOLD LUBERECKI, SR. 2903 EASTERN AVENUE BALTIMORE, MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, FEBRUARY 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12,2011 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) T.STANISLAUS CEM 22. Name and Address of Facility ACZOROWSKI FUNERAL HOME, PA permit. 21. Signature of Funeral Service DUNDALK AVENUE BALTIMORE, MD 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. Li complications that caused the death. only one cause on each line. Immediate Cause (Final **Physician** respiratory disease or condition resulting in death) /Medical **Examiner** cel Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of physician and is the burial-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as 1 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day detached for 5 Other (specify) the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 4 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home Hospital: 1 Inpatient 1 ☐ Yes 2 No 3 🗆 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) မ After this 27. Manner of Death 28c. Injury at Work? Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) or Attending Injury 5 Pending investigation 1 Tes 2 No death. 2 Accident Director; Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Vithin 2 29c. License number 29b. Signature and title of confide 29d. Date signed (Month, Day, Year) RES-000 February

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

1 5 2011

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

r's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:30P. Mary Frances McCubbin М February 2011 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Balto. Oak Crest If Under 1 Year If Under 24 Hrs. 8. Date of Birth X . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth

9. Birthplace (State or Foreign

Feldeth & Pryseal 3, 1936 Country) Funeral 247-50-1088 1 🗆 M 2 💢 F 74 Months Hours Director Mississippi Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City. Town or Location Director r 28a-f sl notified 1 🗆 Yes 2 🔀 No Parkville Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō I 2 should be filed within 72 hours after death with the tith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be retremmatic event, Funeral 21234 USA 8832 Walther Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. ð 1 Never Married 2 Married 21215-0036 1 Yes 2X No Specify: White Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Newspaper Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ဂ္ Unknown Unknown and 2 should to Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Graveswood Court Parkville, Md. 21234 Catherine McCubbin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Easton, Md. 2-11-2011 Woodlawn Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility . Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 24 hours after death. Funeral Director, After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural

Accident 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed co 1234 filed (Month, Day, State 5 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 10, Physician/ 10:35_MPN Peter Joseph Mazzaferro Jr. 2**b**11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Lutherville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 2KM 2 - F Months Hours (Month, Day, Year) 1935 75 Maryland 219-30-7993 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Middle River 1 res 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 202 Middle Way Rd. Apt. 21220 United States items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 'natural", or Specify. 3 Divorced 1 Yes 2 No Completed White Year or Dates within 72 hours the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Hauling filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည and 2 should be Peter Joseph Mazzaferro Sr. Geneva Paciarelli 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Paula Brunell /Daughter 202 Middle Way Rd. Apt. 1D Middle River, MD 2122 20a. Method of Disposition 20b. Place of Disposition (Name of Pate Feb 12 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Chesapeake Crematory Beltsville, Maryland 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives Mo 144 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician COLON CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 🗌 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No ☐ Yes Yes 25. Was case referred to medical examiner? of Vital Be 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 X Natural 5 Pending Division Accident 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the Within 2 TX Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and tifle of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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PETER

10:35

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State 31. Date filed (Month, Day, Year)

CRNP 2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

filed (Month, Day, Year)

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		4a. Facility Name (if not institut Johns Hopkins Hosp	ion, give street and number)	41	o. City, Town, or L Baltimore	ocation of Deat	h	4c. County of	Death
Funeral		5. Social Security Number		ge (In yrs. I	ast birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of E	Firth (MM/DD/YYYY)	9. Birthplace (State or
Director		214-27-7267	1 M 2 F		21 Yrs.	Months Days	Hours Min	12/1	1/1989	Foreign Country)
any		Usual Residence of Decedent 10a. State 10b. County	,		Town or Location					10d. Inside City Limits
·land -f show	tor	MD		Chi	aHimon					1 Yes 2 No
with the Maryland ns 23a or 28a-f sho	Funeral Director	10e. Street and Number	Avenue			10f. Zip Code 2220	6		10g. Citizen of What $\mathcal{U} \mathcal{S}$	
h with ems 23.	eral	11. Marital Status	12. Was Deceden		S. 13. Was	Decedent of Hispa	anic Origin?(S	Specify Yes or N		American Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland nial Hygeine. rked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once	by Fur	3 Widowed 4 Di	1 Yes 2 ivorced If Yes, Give Year or Dates:	No.	1 🗆 🔻	res 2 No	specify:		Specify:	Black
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21215-0036 uid be filed within 7 Mental Hygiene. marked other that	Be	17. Father's Name (First, Middle Joseph Mc	Fadden Sr				Monic	a Wi	Maiden Surname)	
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Baltimore permit. Pages 1: Department of H Important: If it		4 Donation 5 Other S	Specify:	CC	aklawn	<u>Cernefer</u> me and Address d	4 21	16/2011	(Ka/+11	1074, Maryland
Department of the position of		2). Signature of Fulleral delvio	355		Vau	ahn C.	Greene	F.S. &	Kaltinger	KAN 21217.
Physician /Medical		23a. Part I. Enter the disease, o		the death.	Do not enter the	mode of dying, su	uch as cardiac	or respiratory a	rest, shock, or hear	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Woun Due to (or as a cons			ırm				Death
	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons							
	Examiner	name. Enter Underlying Cause (Disease or injury that initiated								
executed an and al - transit		events resulting in death) Last	d							
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	an/M	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	I I Tive pirti		2 Feta	death 3	Ectopic pregna	ancy	23d. Date of d Month	lelivery Day Year
Box 68 e death certi the attendin ed for use a	Physicia		4 Pregnant at	time of dea	ath 5 Othe	r (Specify)			1	
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Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No	ATT OF T	ent 2	ER/Outpatient		ther -		Residence 6	Other:
ion of tending Pheath. or: After the funeral	tion:		28a. Date of Inju (Month Day.) Feb 8, 2011	iry 'ear)	28b. Time of Inju 1831 hrs	´ l _ ´ `	at Work? s 2 ✓ No	28d. Describe Subject sho	how injury occurred ot	İ
Division pital or Attendir ours after death.	ertification:	3 Suicide 6 Cou				factory, office buil	lding, etc.	or Town,		or Rural Route Number, City
Division of Vital Records, P.O. Box 6 within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendic completely filled in by the funeral director, page 2 should be detached for use	Medical Ce	29a. Certifier (Check only 1 Certifying P	hysician: To the best of maminer:On the basis of exa	y knowledg	ge, death occurre			due to the cau	se(s) and manner a	as stated.
To To Com	Med	29b Signature and title of certification	and manner stated. er			29c. License r	number		29d. Date signed	(Month, Day, Year)
		Patr. Use	n - Poll	les.	~	O.C.M.	.E.		February 9,	2011
	ſ	 Name and address of persor Patricia Aronica-Polla 				00 W. Baltimo	ore Street, E	Baltimore, M	ID 21223	
		31. Date filed (Month, Day, Year)		r's Signatu	re		· · · · · · · · · · · · · · · · · · ·			
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DHMH 17 Rev 1/20 OCME 2006	<i>I</i> U1		OCME		ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00:52 AM Kobsevelt Martin February a 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 248.38.3874 Months SC 24 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Saltimore 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zìp Code 10e. Street and Number US4 -UICOH Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roosevelt Martin, Sr. Annie Bell ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any Injury or other traur once. Belcamo MD 21017 anya mompson Dowery Lane Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 0218/2011 Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Excerte Fineral Since 21. Signature of Funeral Service Licensee Road Landall stown ND21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he, rt failure. List only one cause on each line. Immediate Cause Final **Physician** ancreatic Week concer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes Martin, hin 24 hours after death.

the Funeral Director: After this certific

mpletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 Impatient 2 ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21229 Caton Avenue 2Mannarose 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar FEB 1 5 2011

DHMH 17 Rev 1/2001

Roosevelt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:13 A Sr. February 2011 Charles Edwin McCain, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner B<u>altimore</u> Gilchrist Center Towson Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours (Month, Day, Year) une 5, 1919 Director 577-26-5266 91 June Alabáma Usual Residence of Decedent or 28a-f show a notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Towson 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 27 is marked other than "natural", or items 23a of traumatic event, the Medical Examiner must be Completed by Funeral 615 Chestnut Avenue, #314 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12 Agri<u>culture</u> 02 State Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jefferson Pattillo Pattillo McCain Nonnie Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara C. McCain/Daughter Deer Park Road, Westminster, MD other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/12/11 1 X Burial 2 Cremation 3 Removal from State injury or Denation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road, Timonium, MD 2109 any W. Clary the disease, or complications that caused the death. Do not enter art failure. List only one cause on ach line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List only one shock, or heart failu Immediate Cause (Final Physiciani disease or condition resulting in death) OCQU Medical Due to (Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner s been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant a Pregnant at time of death Unknown ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 astrolle 24a. Was an After this certificate has perform 2 X N 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1
Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 No Accident Investigation after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical - rtifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completed

within 2 To the F

(Check

only one) Sign

e and title

Day, Year) 5 2(11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 5

32. Registrar's Signature

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Partifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DOO 71287

29d. Date signed (Month. Day, Year)

te 4105 Baltimere, MD 21204

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joanne V. Morgan February 9, Day 2011 10:50 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Baltimore Towson 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Month, Day, Ye March 26 1 M 2 4 F Months Hours Mary Land Director 216-42-9675 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No N/A Maryland Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4429 Newport Avenue USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2xx Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jane D. Slonaker Charles A. Lego 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Morgan, Sr. 4429 Newport Avenue, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/14/2011 orraine Park Cemetery Woodlawn, Maryland 21. Signature of r eral Service Licenses ²² Name and Address of Facility
Burgee Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Examiner o (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ the past 18 months?

Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown been signed the should be detected to the should be detected to the should be detected to the should be sh Part II<u>. Other significant conditions</u> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 1 Tyes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 10 d address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Augusta Marie Mattocks February 2011 3:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 🛛 F June 2, 1936 577-54-2946 Yrs Director 74 Virginia Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 0 1 Yes 2 No Maryland Montgomery Derwood 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7815 White Cliff Terrace 20855 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 21215-0036 1 Yes 2 XNo Specify: Completed 3 Divorced 4 Divorced Specify: Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hv-Important If item 27 is many injury or other 12 Domestic Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Yuille Edith Britton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jurl O. Mattocks/husband 7815 White Cliff Terrace Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/15/2011 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, M 21. Signature of Funeral Service. Beverly L. M00957 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardia Medical Due to (o as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to tor as a consequence on. b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and it be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 1 ☐ Yes 2 y g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 Wo 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 17 No Hospital Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No M Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 10,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Sherrill MD 9901 medical Ctr MD 20850 Deborah 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Thomas Morton 45 PM 01 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Hamilton Nursing Home Baltimore N/A 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign County) 8. Date of Birth **Funeral** 031-54-9497 Days 1 □**X**M 2 □ F Hours JuMosth, Day, Year 959 Director Usual Residence of Decedent 10b. County N/A ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10c. City, Town or Location Baltimore with the Maryland 10d. Inside City Limits Director MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6040 Harford Rd 21214 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify White 3 Divorced 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other thermany injury or other traumment. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Minister Church 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles F. Morton, Sr. Joan Avery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F. Morton, Sr/Fath 12 W. Broadway Apt.205 Derry, NH 03038 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X remation 3 Removal from State Final 4 ☐ Donation 5 ☐ Other (Specify) 2/14/11 Journey Woodbine, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charisse N. Woods F/S 2700 Edmondson Ave. Balto., MD 21223 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIROT Physician/ PAILURE OR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner UGGING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): BNED HON vate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RHEUTRTOIN RRTHRITIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? OSTGOARTHRITIS 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🔀 No Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending injury Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 7-6-13 RES DOD 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASSILA

DHMH 17 Rev 7/2009

State Registrar

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JEAN 31. Date filed (Month, Day, Year) 5601 LOCA RAVEN BLUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ February 9, 2011 11:13 P M Muralidaran Kalaiselvi Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Hours Min (Month, Day, 513-08-2064 Months 1968 India Director 42 June 6, Lisual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4302 Quanders Promise Drive 20720 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes Give Specify: Asian Indian Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Malliga Adhimuthumalai Chidambaram Ayyanar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4302 Quanders Promise Drive Bowie, Maryland 20720 Muralidaran Karuppiah / Husband| 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Montgomery 1 Burial 2 X Cremation 3 Removal from State February Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) torium Inc 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. M01607 7557 Wisconsin Avenue Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician meta static Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law equires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year 1 Yes 2 Unknown Pregnant at time of death Month signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown theen si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has t autopsy this certificate 1 Yes 2 No 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: ျှ 1 🗌 Yes 1/ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1, Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tit of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 0589 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephe 2001 Medical Parkway Annapolis, MD 21401 FEB 15 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Melvin Mathison 02/13/2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birtl 1**X** M 2 □ F 215-14-4304 87 02/20/1923 Director Usual Residence of Decedent should be filed within 72 mouse and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citi USA Funeral 21227 2816 Pennsylvania Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces2 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Be 17. Father's Name (First, Middle, Last) Mathison ပ Laurents permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print)
Ethel V. Mathison / Wife 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
W. Arundel Crematory 02/15/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ morremo disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed mnala om that initiated events resulting in death) Last Due to (or as a consequence of physician a s the burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death been signed by the should be detached g Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an page 2 s certificate has performed' Yes 2 N Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 A No Other: 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 Pending s after death. 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital or within 24 hours at To the Funeral D 29a. Certifier

10d. Inside City Limits 1 Yes 2X No . Citizen of What Country? 14. Race - American Indian. Black, White, etc. White 16b. Kind of Business Industry Engineering 18. Mother's Name (First, Middle, Maiden Surname)
Tilda (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2816 Pennsylvania Ave., Baltimore, MD 21227 20c. Location - City or Town, State Odenton, MD 22. Name and Address of Facility Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) mv 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oh NI Cran 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

12:34р м

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0900 A M ERIC QUOVADIS Eburary 2011 MILLS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ba laryland 405P, tal HIMDRE N/A 5. Social Security Numbe . Age (In yrs, last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Davs Hours Min. MARYLAND 56 Yrs 1955 Director 214-64-7814 Usual Residence of Decedent 10a. State 10b. County 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location Director 1XXyes 2 □ No N/A MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1604 ASHBURTON STREET 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 73/75 1 ☐ Yes 2 XXNo Specify:BLACK 3 Widowed 4 XXDivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 12th grade LABORER N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည JAMES MILLS ELOUISE MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELOUISE MILLS/Mother Baltimore, Maryland 21216 1604 Ashburton St., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of IImportant: If ite any injury or ot once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 02-17-2011 OWINGS MILLS, MD. 21. Signature of Fine d Salving 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) vere Medical Due to (or as a consequence of Examiner neumonic EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine M Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 2 No 1 Yes 2 No To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 IV Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 5 Pending 2 No Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, pleted filled in by 4 Homicide determined City or Town, State) 24 hours Medical

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Muota

MAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEVILO 1A, MO

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ 8:39A Frank Thomas Marrichi Feb 13 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth '. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 212-20-5062 10-6-1923 87 **Director** MD Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD Carroll Westminster 1 Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1513 Miller Rd. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked or Sabatino Marrichi Anunziata Michele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marrichi - wife 1513 Miller Rd., Westminster, MD 21157 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Meadow Branch 2-17-11 Westminster, MD 4 Donation 5 Other (Specify) Signature of uneral Service Ligensee 22. Name and Address of FacilityFletcher Funeral Home 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death
Unknown g 🗌 Unknown P.O. ing to death but not resulting in the unverlying cause given in Part I. Part II. Other si nificant c d tions contribut 23e. Did tobacco use contribute to the cause of death? ò Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 HNo Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at MUSSICE 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) 4+1 ompleted cause of death (Item 23a) (Type, Print) DESTHIUSTER MD 21157

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State Registrar filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ reb. 13,2011 Vivian M. McCov 10:43 MA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 3, 1932 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-30-2612 1 🗆 M 2 🖵 F Hours 78 Country) Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4915 Herring Run Drive 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' 1 Never Married 2 Narried Completed by 1 Yes 2 No 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Basil S. Clark Desdie May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond McCoy (husband) 4915 Herring Run Dr. Balto, Md. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 17,20 Burial 2 ☐ Cremation 3 ☐ Removal from St Dulaney Valley Mem.Gardens Towson, Md. Signature of Funeral Service Licenses 22. Name and Address of Facility alvin B. Scruggs Funeral Home 412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastate renal cona Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2/No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Xother} \) (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No in 24 hours after death.

Funeral Director: Aight of the fulled in by the fulled in th 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State

Registrar

80. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Examir	ier	406 Folcroft Stree	*	ľ	•	more, M	D	4c. County	N/A	
	Funeral Director		5. Social Security Number 220-36-1746 6. Sex 1 □ M 2 💆 F	7. Age (In yrs. last bin		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth OCT26,	f941	9. Birthplace (State or Fore Maryland	ign
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	ith the 23a or st be n	10e. Street and Number 10f. Zip Code 10g. Citizen of What Code 406 Folcroft Street 21224 U.S.A.									
	eath w	Funeral	11. Marital Status 12. Was Dece	edent Ever in U.S.	13. Wa	s Decedent of His	spanic Origin? (Spe	cify Yes or No-		e - American Indian,	-
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 🗶 Widowed 4 ☐ Divorced	2. ⊒KNo ∕e	1	es, specify Cubai	Specify:	Rican, etc.)	Blac Specify:	k, White, etc. White	
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Baltimore, Maryland 21215-0036	Page 1 ar		20a. Method of Disposition 1 ☐ Burlal 2 XCremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place o cemete	of Dispositi	ion (Name of tory or other place Cremato	, Febr	wary 20	Oc. Location -	City or Town, State Ore, Marylance	
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Division of Vital Records,	The lav cate has page 2	Completed						autopsy performe 1 \(\sum \) Yes 2	ed? p	erior to completion of cause of leath? Yes 2 No	
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:	vithir Comp comp	_	29b. Signature and title of certifier		-	29c. License	number	290	l. Date signed	(Month, Dav. Year)	
			Julianne Bet	ea Chr	v 6/	MD	2065	248	2/11/	111	
			30. Name and address of person who completed caus Julia NNE Bethea 31. Date filed Month, Day, Year	e of death (Item 23a) (1	Type Print	sternb	tre B	altimor	-P, W1	D 2122 Y	
	Stat Registra	e	31. Date filed (Month, Day, Year) 32. R	egistrar' s S ignature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04302 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. Walter 2011 Namuth 9:45P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore Forest Haven Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD 1 X M 2 🗆 F Hours Min 06-27-42 Director 217-38-7510 68 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Towson 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 531 Stevenson Lane 21286 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

XXYes 2 \(\sum \) No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates, Navv Specify: White 3 Widowed 4 Noivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) NA Elementary/Seconday (0-12) 12th Grade Various locations Musician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o Namuth Namuth, Helen Walter other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvert Street Suite #200 Baltimore Terry Sullivan-Guardian Department of Healt Important: If item 2 any injury or other Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 02-15-11 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Street Baltimore, MD 21217 638 Ν. Gilmor Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗷 No Yes 2 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: မြ

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Other: 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

27. Manner of Death 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be

28a. Date of injury (Month, Day, Year) 28c. Injury at iniury work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certified

determined

BALTIMORE

Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDHU 1940W.

31. Date filed (Month, Day, Year) FEB 1 5 2011

State Registrar

Certificate:

29a. Certifie

(Check

within 24 hours after deatl

To the Funeral Director:
completed filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P Physician/ Year 6:55 2011 Medical Facility Name if not institution, give street and number, Town, or Location of Death Examiner 4c. County of Death In iversity of Manyland Medical Center hmore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** 5Ó Months Days Hours Min (Month, Day, Year 1 M 2 □ F Indiana Director 310-68-7643 1960 Usual Residence of Decedent or 28a-f shov 10b. County be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d, Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🏋 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2613 Thornberry Drive 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Crane Mechanic Crane Service To Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic Avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Lee Nance Sr. Dorothy May Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Susan M. Nance</u> / Wife <u> 2613 Thornberry Drive, Edgewood, Maryland 21040</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 2-17-11 Hilltop Service Corp. Towson, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a onsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.
Funeral Director: After this certificate has autopsy completed filled in by the funeral director, page 2 autop performed 2 2 🗌 No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 200 ၉ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimere 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

11-01085 Stephen Ostman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # State of Maryland Bepartment of Pleatith and Mental Hygiene

	1- For State Certificate of Death Registrar	Reg. No.	1 1450
Physician/	Decedent's Name (First, Middle,Last)	Date of Death Month Day Year	3. Time of Death
dical Examine	beepitali iii obemaii	February 8, 2011	0845 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 3364 Cranberry Street Laurel	of Death 4c. County of Dea Anne Arunde	
Funeral		der 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. E	
Director	214-82-8472	March 16 1961	Country) Alaska
kg a	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
show	MD Anne Arundel Laurel		1 Yes 2 X No
Maryla 28a-f 1 at or	10e. Street and Number 10f. Zip Code	10g. Citizen of What Co	ountry?
3 or otifie	3364 Cranberry S. South 20724	USA	
hours after death with the Maryland bastural", or items 23a or 28a-f sho Examiner must be notified at once 30d by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XX No 13. Was Decedent of Hispanic Or		erican Indian, Black,
e . b	3 Widowed 4 XXDivorced If Yes, Give Year or Dates:		White
hours fragur Exam	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give during most of working life, DO NO		s/industry
2 3 - 0	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Ø Home Improvement:	Const	cuction
21215-0036 uld be filed within 72 hours a Mental Hygene, marked other than "natural c event, the Medical Examin To Be Completed by		er's Name (First, Middle, Maiden Surname)	decion
2 4 8 8 4 0	Robert Ralph Ostman Dia	ane C. Biersack	
hould hould is ma is ma	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu Sc	imber or Rural Route Number, City or Town, Sta	ite, Zip Code)
ore, MD 212 1 and 2 should by of Health and Ment of item 27 is mark or traumatic even	Diane C. Ostman/Mother 3364 Cranberry S 20a. Method of Disposition (Name of cemetery,	Laurel, MD 20724 Date 20c. Location - City	or Town State
Ore, es la of He If ite	1 ABurial 2 Cremation 3 Removal from State crematory or other place)		
Baltimore, cernit. Pages I ar Department of He (mportant: If ite injury or other tr	4 Donation 5 Other Specify: Meadowridge Mem. Pk	2/12/2011 Elkrid	
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic or	21 Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of F	Donarabon rancrar	
Physicían	23a. Farr I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	venue, Laurel, MD 20 cardiac or respiratory arrest, shock, or heart	Approximate Inter
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Cocaine and Alcohol Intoxicati	on	Between Onset ar Death
Examiner	or condition resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, b		
nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
ted Insit Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		18 0
and trans	d.	2_22_11_nt	
760, icate be executed sphysician and the burial - transit i/Medical Exa	■ MENDED 23a,27,28a-f per me g912 23a pt.II per me g913 3-7 IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy	-11 vt	
(68760, certificate be executed nating physician and ise as the burial - trans:ian/Medical E.	23b. Was decedent pregnant in the 1 live high a Fetal death 3 Fotor	23d. Date of delivership pregnancy Month	ery Day Year
). Box 687 the death certific by the attending p ched for use as th Physician/	4 Pregnant at time of death 5 Other (Specify)		
be degree of the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I 23e. Did tobacco use contribute	to the cause of death?
res that the signed by be detach	Throat and Tongue Cancer	1 Yes 2 No 3 Pr	_
In of VITAI RECORDS, P.O. BOX diog Physician: The law requires that the death a. After this certificate has been signed by the atter finneral director, page 2 should be detached for u. on: To Be Completed by Physic		24a. Was an 24b. Were	autopsy findings availal
law re has be		autopsy prior to performed? death?	completion of cause o
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Vital ysician ysician directo	examiner? Hospital: 1 Innation 3 FR/Outpation 3 DOA Other	h (Check only one) Nursing Home 5 Residence 6 V Oth	ner: Scene
n of VII diog Physic After this funeral dire	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Wo		
tendio eath. for: At the fur	1 Natural 5 Pending Fd 2-8-11 Fd 8:26am	No unknown	
DIVISION Of VITAL RECORDS, tal or Attending Physician: The law require standed death. al Director: After this certificate has been sited in by the funeral director, page 2 should bettification: To Be Completed ortification: To Be Completed	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, of the street of t	etc. 28f. Location (Street and Number or I	Rural Route Number, C
DIVISION O Ppital or Attending tours after death. Seral Director: Aft filled in by the fune Certification:	4 Homicide determined (Specify) residence	or Town, State) 3364 Cr Laurel, Anne Arun	del, Md. 2
3 4 5 5	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and proceedings). But the least of a proceedings of a procedure in the process of a procedure in the procedure in	place, and due to the cause(s) and manner as st	ated.
To the How within 24 h To the Fuc completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.		
≥	29b. Signature and title of certifier 29c. License numbe	r 29d. Date signed (N	
5 7kg	(Calorbelle) O.C.M.E.	rebruary 9, 20	
	 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Balti 	more. MD 21223	
State	31 Date filed (Month Day Vear) 82 Registrar's Signature		
Registrar			

Please Type or Print in Black Indelible Ink, Ensure All Gopies Are Legible.

AMEND ITEM#23a, pt I per PYHS, G912, 2/13 All Gopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 9, 2011 Mary T. O'Malley 6:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 501 West University Parkway Apt 5A Baltimore 5 4 1 8. Date of Birth (Month, Day, Year) Sept 27, 1937 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 021-28-2402 1 □ M 2**XX**F Months Director MΑ Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director N/A **Baltimore** MD YY Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 21210 501 West University Parkway Apt. 5A U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 XXNever Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2) No Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Guidence Counselor Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Martin O'Malley Mary Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliette Hanks (P.O.A.) 501 West University Parkway Apt. 5A Balto, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2/12/11 Glen Burnie, MD 22. Name and Address of Facility Furgee—Henss—Seitz Funeral Home, 3631 Falls Road Balto, MD 2121 21. Signate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Alcohol abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence on): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 ANO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident M Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

11-01124 William Ralph O	akes	Please Ty	pe or Print i ttate of Maryla	n Black Ind	lelible Ir	ı k. Ensur Health ar	re All Copi nd Mental H	es Are Lo	egible.	5511	
<u> </u>		I- For State Registrar			ificate of				Reg. No.	CUII	3. Time of Death
Physicia Medical Exami	-11.0	1. Decedent's Name (First, Midd		R.T. 0a	ikes. J	r		Month February	Day 9, 2011	Year	1349 hrs
		4a. Facility Name (if not institution 11001 MacArthur Bot	on, give street and nu			b. City, Town, o Potomac	r Location of Dea	th		county of Death Intgomery	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Yes		_	Birth (MM/DE	Foreig	thplace (State or
Director	-	230-44-7686 Usual Residence of Decedent	1 M 2 F	73	3 Yrs.			Septem	ber 5,	1937 ^{Col}	^{untry} Pennsy1vani
ow any		10a. State 10b. County	,	10c. City, T	own or Locati						10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once.	Director	Maryland Months Months Maryland Months Month	ontgomery			Pot 10f. Zip Code	omac		10g. Citize	n of What Cour	ntry?
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leath wi	Funeral	11. Marital Status 1 Never Married 2 X		cedent Ever in U.S. forces? 2 X No			n, Mexican, Puer		10-	White, etc.	
rs after ural", o	<u>S</u>	3 Widowed 4 Di 15. Decedent's Education (Spe	ivorced If Yes, Give Yes or Dates: ecify only highest gra	ar		Yes 2 X No	specify:	f work done		pecify: What does not be decify: not be decified not be deci	ite ndustry
6 172 hou an "nat	leted	Elementary/Secondary (0-12)					e. DO NOT use re				
5-003 ed withir ygiene. other th	Completed	17. Father's Name (First, Middle	5+ e, Last)	•	_	Investo	18.Mother's Nan	ne (First, Middle		orn, LLC urname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 sho injury or other traumatic event, the Medical Examiner must be notified at once.	B	William R.T. 19a. Informant's Name/Relation		•	19b Mailing	Address (Stre	Anna Ha		umber. City	or Town. State	. Zip Code)
MD 2 12 shoul th and N 127 is n umatic	\vdash_1	Delores Bromle			12 Ga	te Post	Court,	Potomac	, Mar	yland 2	20854
Ore, ges l and t of Heal : If iten ther tra		20a. Method of Disposition 1 Burial 2 X Cremation	on 3 Removal fi	rom State Mont	ematory or oth	tion (Name of ce er place) 7	Fel	Date		cation - City or	
altim mit. Pag pariment portanti ury or o	1	4 Donation 5 Other S 21. Signature of Funeral Service		Cre	natorii	ım, Inc.		, 2011			Maryland nesta- vy chase, Im
	3 8	23a. Part I. Enter the disease, o	house that of	MO1530	0 1755	7 Wisco	nsin Ave	enue, Be	ethesd	la, Mary	yland 20814 Approximate Interval
Physician Wedical Examiner		failure. List only one cause Immediate Cause (Final disease	e on each line.	unshot Wound							Between Onset and Death
ZAdillilei		or condition resulting in death) Sequentially list conditions,	Due to (or as a	a consequence of):							
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be execut	dical	UNPENDED	AMENDED								
.O. Box 68760, that the death certificate be exected by the attending physician detached for use as the burtal.		IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live		₂ Fe	al death 3	Ectopic preg	nancy		Date of delivery fonth	V Day Year
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exervithin 24 hours after death. To the Fuoreral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burnal.								24a. Wa	as an topsy		topsy findings available
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fital Rec sician: The is certificate lirector, page	å	25. Was case referred to medic examiner?	71.1	Inpatient 2 E	R/Outpatient		of Death (Chec		Residence	ce 6 🗸 Other	r: Scene
Division of Vital pital or Attending Physician: ours after death. eral Director: After this certif	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Dear	28a. Date	h Dav Year)	28b. Time of I Unknown	· · _	ury at Work? Yes 2 ✓ No	28d. Describ	e how injury		
risior r Attend er death irector: n by the	fication	2 Accident Inve	estigation	ce of Injury - At hor		4-1-				Number or Ru	ıral Route Number, City
Div spital or hours aft ocral Di	Cert	4 Homicide det	ermined (Specify	Park/Recrea				1	Arthur Bou	levard, Potor	
Divisior To the Hospital or Attend within 24 hours after death. To the Fluorral Director: completely filled in by the t	Medical	(Check only Certifying i	Physician: To the be caminer: On the basis and manner	of examination and	e, death occur d/or investigat	red at the time, of the control of t	date and place, all on, death occurred	nd due to the ca d at the time, da	ause(s) and ite and place	manner as stat e, and due to th	ed. ne cause(s)
F 3 F 8	Š	29b. Signature and title of certif					se number		1	ate signed (Mo uary 10, 201	
		30. Name and address of person								,,	
12		Pamela E. Southall,	MD Assistant	Medical Exam	niner 900	W. Baltimo	re Street, Ba	ltimore, MD	21223		
St Regis	tate trar	31. Date filed (Month, Day Year FEB 1 5 2	011 Due	Cysual S Signatur	back	j .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of M	laryland / Dep <i>Ce</i>	artment of H rtificate of D			ene .g. No.2 U	04307	
Physic		Decedent's Name (First, Middle, Last) Elizal	beth Ann	e O'Don	nell	2. Date of Death Month Februa		3. Time of Death 11 3:27 pm M	
Exam	lical iner	4a. Facility Name (if not institution, give street and number) Stella Maris Hospice		4b. City, Town, or I	Location of Death		4c. County of Dec		
Funera Directo		5. Social Security Number 6. Sex 1 \square M 2 \square XF 7. Ac	ge (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1 1 1 9 7 1 9	9. B	rthplace (State or Foreign ountry) Ohio	
yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County OH Miami	10c. City, Town or Lo		ington			10d. Inside City Limits	
th the Mar 3a or 28a- t be notifi	Funeral Director	10e. Street and Number 102 East Bridge Street		10f. Zip Code 45318		10	Og. Citizen of What C		
ore, Maryland 21215-0036 pt 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	à	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Armed Forces? 1 Yes 2 Married	r ≹No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🔀 No	panic Origin? (Spe , Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W		
Maryland 21215-0036 12 should be filed within 72 hours after tith and Mertial Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 12)	5+) (Give	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse			16b. Kind of Business Industry Healthcare		
Maryland 2 d 2 should be filed w alth and Mental Hyg n 27 is marked othe er traumatic event,	To Be	17. Father's Name (First, Middle, Last) Joseph Dickerson			18. Mother's Name	e (First, Middle, Ma		unkn.	
Mary d 2 should alth and M 27 is ma		19a. Informant's Name/Relationship (Type, Print) James O'Donnell / Husband	19b Maili 102	ing Address (Street at East Brid	nd Number or Rura ge St., C	Route Number, (OVINGTON	City or Town, State, 7 OH 4531	ip Code)	
Baltimore, permit. Page 1 and Department of Hea mportant: If item any injury or other	(1)	20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	- · ·	osition (Name of matory or other place irney Crem	loodbine,	dbine, MD			
Baltimor permit. Page 1 Department of Important: If it	OIICE.	21. Signature of Funeral Service License Dorota	Marshall 2	2. Name and Address Mary	land Cre	mation	Service	s 21203	
~ Ph _y siciar	t,	Approximate Interval Between Onset and Death							
Medica Examine	er		a consequence of):						
cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or linijury that initiated events c.	за попведиелом :ф:						
760 icate be executed physician and sthe burial-transit	edical E	resulting in death) Last Due to (or as	a consequence of):						
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me		2 Fetal death 3 at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	1		23d. Date of d Month	elivery Day Year	
ords, P.O. v requires that the been signed by should be detact	ed by Ph	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown	
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director After this certificate has been signed in by the funeral director, page 2 should by	Completed					24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of	
Vital Re oysician: The last certificate his director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input	tient 2 🗆 ER/Outpatie	_ Other	ce of Death (Check	, ,	nce 6 X Other (Spe	ecify) HOSPICE	
on of V nding Phys ath. r: After this e funeral di	Certificate: 1	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	ury 28b. Time o	of 28c. Injury work?	at 2	28d. Describe hov			
Division of all or Attending P is after death. In Director: After the in by the funera			jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,	
Divisi To the Hospital or Atte within 24 hours after de To the Funeral Directo	Medical	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Ch	examination and/or inves	stigation, in my opinior	n, death occurred at	the time, date and	place, and due to the	e cause(s) and manner stated.	
To t		29b. Signature and title of certifier	0	29c. License	number 19792	29	9d. Date signed (Mon	th, Day, Year)	
\		30. Name and address of person who completed cause of			MT1601-12-	1m 015	00		
	tate	31. Date filed (Month, Day, Year) 32. Registr	DULANEY VAI	barl	TIMONIUM	MD 210	93		
Regis	trar	FEB 1 5 2011 ▶2	ever B.	your					

DHMH 17 Rev 7/2009

FEBRUARY 12, 2011 3:27 p.m.

ELIZABETH ODONNELL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G939 5/06/2013 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 10,201 Tear 8:35A. Anna Elaine Papa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8 Broadbridge Road Roseda1e Balto. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min October 27,1934 Maryland 76 Yrs. Director Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f sho 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Balto. Rosedale Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 8 Broadbridge Road Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 12+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Ripple Mary H. Bull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 8 Broadbridge Road Rosedale, Md. 21237 Rose M. Papa 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \square Burial 2X Cremation 3 \square Removal from State 2-11-2011 Balto.MD. Bayview 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Annroximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) STOMACH CANCER) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Gause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nas performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 🔀 No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No М Accident Suicide Investigation 6 Could not be 3 ☐ Suícide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 3 Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1143725 10 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar TARIO MAHMOOD,

31. Date filed (Month, Day, Year) FEB 1 5 2011 MD

a.l

2011

FEBRUARY

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Dep.	artment of Health and N <i>rtificate of Death</i>	lental Hygiene Reg. No.	
			Registrar 1. Decedent's Name (First, Middle, Last)	Timoato or Boati.	2. Date of Death	3. Time of Death
	Physicia	an		Pitt	Month Day	2011 7:30a. M
2	/Medic		Tia Jackson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	unty of Death
لہ	Examin	er	Genesis Health Center	Baltimore		
A)			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Funeral Director		215-82-8175 1 M X F 46 Yrs.	Months Days Hours Min.	(Month, Day, Year) 12 01 64	. Country) MD
	tot or		Usual Residence of Decedent		122 02 01	
	land ow	Ì	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary f sh	ţ	MD Howard Colu	ımbia		1 □Yes 2 X No
	the 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?
	3a ol		10342 College Square	21044		U.S.A.
	ns 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		Race - American Indian, Black, White, etc.
10	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at		1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No			
က္က	urs a	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Spi	ecify: Black
2-003	be filed within 72 hours after death with the Marylar trtal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation	16b. Kind o	of Business/Industry
2121	filed within 72 Hygiene. kther than "nai kther the Medic	g	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		
2	gien gien the	ю	12th grade na Fo	ood Service's		I.A.
b	e filed al Hygi other vent, t	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Sur	name)
<u>a</u>	ould be t Mental arked o	70	William Jackson Sr.	Marlen		
Maryland	2 should be filed v and Mental Hygie Is marked other t raumatic event, th	ľ		ing Address (Street and Number or Ru		
	12 m			12 College Squa		
more,	/\ O L		20a. Method of Disposition 1♥ Buriat 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of ematory or other place)	Date 20c. Locati	ion - City or Town, State
Ĕ	Pages nent of I ant: If Ite		4 Donation 5 Other (Specify) New Ca	athedral 2/8/	2011 Balt	imore, Md
att	permit. Page Department of Important: If any injury of		21. Signature of Funeral Service License	22. Name and Address of Facility March F/H West		
m	a II De			1300 Wabash Ave	, Baltimore	Md 21215
П			23a. Part1 Enter the disease, or complications that caused the death. Do not el show, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician	1	Immediate Cause (Final METASTATIL	ArcinomA.1	BONG BYAIN.	Onset and Death
	/Medicai		resulting in death) a. Due to (or as a consequence of):	7	11111	2(1)
	Examiner		Breagt C	AVCENOMA,		2007(324
	1000	Jer	if any, leading to immediate Due to (or as a consequence of):			
2.	cuted	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c.			
) P	an ar rial-tı	EX	resulting in death) Last Due to (or as a consequence of):			
£0928	ficate be executed graphysician and is the burial-transit	dical	d			
w	rtifica ng ph as tt	Med	The second secon		-	
ŏ	leath certific attending p	N/UE	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d	d. Date of delivery Month Day Year
m	deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month Day Teal
Ö	that the de led by the a detached t	Physician/Me	9 L J Unknown			
Vital Records, P.O. Box	The law requires that the death certifite has been signed by the attending vage 2 should be detached for use as	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		contribute to the cause of death?
פֿ	w require been się should k	ed	OVARIAN CANCIEL		1 Yes 2 I	No 3 Probably 4 Unknown
ည္က	aw requisible been 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available
ď	The I	mo			performed? 1 Yes 2 No	prior to completion of cause of death? 1 □ Yes 2 □ No
ta		BeC	25. Was case referred to medical	26. Place Dea	ath Check onl one	
>	yslcian: is certific director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing F	lome 5 Residence 6 □	☐Other (Specify)
0	g Physer this neral di	Ë	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how injury of	occurred
io n	nding I ith. r: After e funer	igi	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division or	Atte	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Street and f City or Town, State)	Number or Rural Route Number,
Ö	al or afte	Certification:	Failuring, etc. (openity)		1	
	bours hours uners ly fille		29a. Certifier (Check only (C	ath occurred at the time, date and place	e, and due to the cause(s) ar	nd manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ		
	To the within To the comple	Ž	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
	Δ.		DENIET (MUZA MO	0004709	16 21	7/2011
	2		30. Name and address of person who completed duse of death (Item 23a) (Typ	e, Print)	7 -	100 0.015
			30. Name and address of person who completed truse of death (Item 23a) (Typic RENNESS) LINPUSERS M.D. (Item 23b)	4 12 MELICENTE AVE	13 ALIMINE	UND 212(2
लेव	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	del		
30	Regist	rar	FER 15 2011 /2 2021 12 2000	4		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 11EM#20b, perFH, G912, 2715/2011, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #1, per MD G912 2/28/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month MERRIDITH ELAINE PERSON 2011 9:15 A^{M} Meredith Elaine Person Februar 8 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11–8–194 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Days 1 □ M 2 🔽 F 69 Months Hours Country) EW JERSEY 152-32-8292 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location aţ Director ral", or items 23a or 28a-f s Examiner must be notified **ESSEX** NEWARK 1 X Yes 2 No NEW JERSEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA PROSPECT 07112 555 MT. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or by 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: BLACK Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. within 7 NEWARK BOARD Elementary/Seconday (0-12) College (1-4 or 5+) RETIRED CASHIER OF EDUCATION Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is many injury or other. filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY FRANCES JONES 2 JAMES GARFIELD EDWARDS SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 LONG RIDGE RD. REISTERSTOWN, MARYLAND GARNET PERSON(SON) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2-14-2011 1 X Burial cemetery, crematory or other place) 2 Gremation 3 K Removal from State 4 Donation 5/ Other (Specify) FAIRMOUNT CEMETERY NEWARK, NEW JERSEY JONATHAN D. HIBNER. Name and Address of Facility 21. Signature COTTON FUNERAL SERVICE 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immedia Cause (Final NEW JERSEY 07050 Approximate Interval Between Onset and Death Pnysician/ prologenic TOOK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner lial Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the business. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 N 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 No Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 No Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Chalken More 8 2090 1201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md 2120 6701 Marie Chathani Day, 31. Date filed (Month 32. Registrar's Signature State arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7&8 Per FH G912 2/23/2011 JH State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month 6:40 AM Mildred Edith Roberts February 14, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson Year) 1918 If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jul 03 Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days Mir Hours 1 M 2 M 92 93 Director 191 Marvland 212-40-6066 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director must be notified 1 Yes 2 No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 W. Bel Air Avenue Apt. 21001 United States 408 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces Black, White, etc. 1 ☐ Yes 2 ►No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 Widowed 4 Divorced White Year or Dates and Mental Hygiene.
is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard W . Taylor Erma Pruitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oartment of Health a sortant: If item 27 is injury or other tra Martha Aqui /Daughter 700 W. Bel Air Avenue Apt. 408 Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 cremation 3 Removal from State Feb permit. Page Department o Important: If any injury or once. 15 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signaftyre of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to in mediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown certificate has been sir rector, page 2 should h Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗆 No 1 Yes 2 No Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: Other: 2X No 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical cortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 007128 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO LIZOU JOHN.C lil 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Russell February 2011 Physician/ YM Medical 4c. County of Death Jown, or Location of Death Name (if not institution, give street and number, Examiner MOVE 8. Date of Birth 9. Birthplace (State of Foreign If Under 1 Year Country Funeral Min Months Yrs. Director Usual Residence of Decedent 10d. Inside City Limits Town or Location 10c. City 28a-f shov 10b. County 10a. and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No imore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö by Funeral 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Baltimore, Maryland 21215-0036 Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during fe. JO NOT use retired) most of working (Specify only highest grade completed) College (1-4 or 5+) onday (0-12) hin 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, ဂ္ City or Town, State, Zip Code, 19b. Mailing Address (Street and Number or Rural Route Number, 19a, Informant's Name/Relationship (Type, attimore anvale item 27 injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Department of H Important: If ite any injury or ot Page 1 Burial 2 Cremation 3 Removal from State 2011 wings arrison ores 4 Donation 5 Other (Specify) 22. Name and Address of Facility Youghn C Greene 5751 Balthure permit. 21. Signature of Funeral Service Licensee National National once. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Unknown ancer. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 . If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown IF FEMALE 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Day Year in the past 12 months?
1 Yes 2 No should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completic death? 1 \(\text{Yes} \) 2 \(\text{Y} \) autopsy page 2 s performed Yes 2 26. Place of Death (Check only one, 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be HOSPICE examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 1 Yes 28c. Injury at work? 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Mann r of Death Certificate: injury Natural 5 Pending 1 Yes 2 No M Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifle 2011 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 aven 21218 Baltimore Mary

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

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ranke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alicia Rodefer February 2011 1:18 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min. 1 M 2 1 F Months Days Hours 578-13-1195 Yrs Director Colombia Usual Residence of Decedent show 10a, State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1805 Powder Mill Road 20903 United States 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 KNo 1 XYes 2 No Specify: Colombian filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates Specify: White "natural" Completed 3 Widowed 4 KDivorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Private Housing 12 Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed trment of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic ever ပ Jesus Valencia Tulia Gonzalez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Osorio/granddaughter 8122 20th Avenue Hyattsville, Maryland 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hinal Journey Crematory 2/16/2011 Woodbine, Maryland 21. Sign 22. Name and Address of Facility Coing Home Cremation Beverly L. Heckrotte, re of Funeral Service Lie ion Service P.O. Box te, P.A. Clarksville uanita M00957 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Anproximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Vascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? page 2 should be detached for Day Year Pregnant at time of death 2X No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 21 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of After 1 28c. Injury at 28d. Describe how injury occurred 2 Accident
3 Suit 5 \square Pending iniury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

DHMH 17 Rev 7/2009

only one

29b. Signature and title of certifier

Steven Wilks.

31. Date filed (Month, Day, Year)

eva

Ws

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

mos

32. Registrar's Signature

29c. License number

D0063195

6001 Muncaster Mill Road Rockville, Maryland 20855

29d. Date signed (Month. Dav. Year)

February 13,

2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0.2^{Month} 0^{Day} 20111 Dessie Rhue 2:24p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore CO. Gilcrest Hospice Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X** F Min. Hours 09^M/14^D7^y1^y9ⁿ63 Maryland **Director** 47 213-84-5378 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at by Funeral Director 1 X Yes 2 No N/A Baltimore 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Seabury Rd. 21225 U.S.A. 2 should be filed within 72 hours after death ith and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>11th Grade</u> <u>Homemaker</u> N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic evence. 0 James Rhue Sr. Daisy Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron Chever (son) 3000 Seabury Rd., Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill 02/18/11 Cedar Cem Baltimore, MD e and Address of Facility eph H. Brow N. Fulton 21. Signature of Funeral Service bicensee mJr; Funeral Home PA Baltimore, MD 21217 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between mediate Cause (Final mease or condition Onset and Death Physician/ MDS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or finjury that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year To the Hospital or Attending Physician: he law 'equires that the dee within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 📈 o 3 ☐ Probably 4 ☐ Unknown To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 5 Pending Division Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat re and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARLERES 5701 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) P M 2011 2:45 February Physician/ Romano Patricia Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Rockville Montgomery Hospice Casey House 8. Date of Birth 9. Birthplace (State or Foreign Year If Under 24 Hrs. . Age (In yrs. last birthday) If Under 1 Massachusetts Social Security Number Min October 29 Hours Davs **Funeral** 1 □ M 2 🕱 F Months 72 028-28-2392 Director Usual Residence of Decedent 10d. Inside City Limits and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State Director 1

Yes 2 □ No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number United States by Funeral 20878 3 Marquis Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 72 hours after death 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Maryland 21215-0036 If Yes, Give 3 X Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) City of Gaithersburg College (1-4 or 5+) Elementary/Seconday (0-12) filed within Office Manager 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Gertrude (Unknown) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ဂ္ Walter Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14415 Oakvale Street, Rockville, Maryland 20853 Joseph D. Romano III / Son 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) February 16, 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State Rockville, Maryland 2011 Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01360l 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Small Cell Lung Cancer Physician/ resulting in death Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consucuence of): Examiner Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Is Inneral Director: After this certificate has been signed by the attending physicial Box 68760 IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? Other (specify) 2 X No Yes 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 X Unknown Records, Completed page 2 should Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 X No 1 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 2 🛛 No ည 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral Certificate: 1 🗶 Natural 5 Pending 2 🗆 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide Homicide determined 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier

the within To the 2

> State Registrar

29b. Signature and title of certifier

6001 Muncaster Mill Road, Rockville, Maryland 20855 M.D. <u>Bindu Joseph.</u> 31. Date filed (Month, Day, Year) FEB 1 5 2011

30. Name and address of reson who completed cause of death (Item 23a) (Type, Print)

29c License number

D0060634

29d. Date signed (Month, Day, Year)

February 11, 2011

			For State	State of Ma	aryland	-	ertment of He		nd Mer			71111	14316
			Registrar 1. Decedent's Name (First, Middle, L	act)			IIIICALE OI D	eaur	2.	Date of De	Reg. No	A	3. Time of Death
	Physici	an	Blanc		Pot	ondi				Month bruar	Da	y Year 2, 2011	
	/Medic Examin		4a. Facility Name (If not institution, g		ROU	Ondi	4b. City, Town, or L	ocation of		.DI dai	_	. County of De	
1	Examin	E	Springhouse at				Bet	hesda	9			Montgon	erv
	Funeral			Sex 7. Ag	e (In yrs. las			If Under 24 Hours	4 Hrs. 8. Min.	Date of Bir (Month, Da	th ı <i>y, Y</i> ea <i>r)</i>	9. B	rthplace (State or Foreign Country)
	Director		040-03-2295	ILM ZUAF	98	Yrs.			Se	ptembe	r 19,	1912 C	onnecticut
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary Fied a	to	D.C.				Was	hingt	ton				1 X Yes 2 □ No
	h the	Director	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What C	Country?
	th wit		3541 39th Str	eet, NW #F	- 510		2	20016			U	nited S	tates
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of His f Yes, specify Cuban	panic Origi , Mexican,	in? (Specify Puerto Rica	Yes or No an, etc.))-	 Race - An Black, Wh 	
36	s afte	by Fi	1 Never Married 2 Married 3 XWidowed 4 Divorced	If Yes, Give	No.		I∐Yes 2⊠No	Specify:				Specify: T.	Thi + a
9	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, it is Mudical Examiner must be notified at	edk	15. Decedent's	Year or Dates:		16a. Dece	ient's Usual Occupat	tion			16b. K	ind of Busines	hite s/Industry
215	in 72	Completed	(Specify only highest g Elementary/Secondary (0-12)		+)	(Give life.	kind of work done du DO NOT use retired)	uring most (of working				
21	filed within Hygiene. other than ent, the M	E O	12	College (1-40) 3	17)	-	Homemak					wn Home	
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Las				1	18. Mother	's Name (Fi				
yla	ould to	ဥ	Ignat		ek			-				wavski	
Mar	12 sho th and 7 is ma trauma		19a. Informant's Name/Relationship				g Address (Street at						
e,	s 1 and 2 should be filed withir f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Ma		Jane Dell'Amore	/ Daughte			SYEN SERE sition (Name of natory or other place,		Date			ocation - City of	D.C 20016 or Town, State
lon I	ages ent of it: If it		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec					; = ;	ebruary 2011	- 1	C + 1,	uan Can	ing, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 ar Department of Hes Important: If item any injury or other once.		21. Signature of Funeral Service		Gale		ven Cemetery						yChase, Inc.
ä	permi Depar Impor any ir once.		> John J. Fr	***	M0136		57 Wisconsi						•
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each li	the death.	Do not ent	er the mode of dying	, such as o	cardiac or re	spiratory a	rrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	-		stive	Heart Fai	llure					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as									
		Je .	Sequentially list conditions,	b Due to (or as			ficiency						
Λ.	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Hypert		on						
为	an and	Exa	resulting in death) Last	Due to (or as									
8760,5	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical		d									
39	ertifica ling pl	Med	IF FEMALE:										
Box	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal d	leath 3[Ectopic pregnancy					23d. Date of o Month	lelivery Day Year
P.0.	he de	Physician/Me	1 □ Yes 2 🖾 No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	atn 5L	Other (specify)						
σ.	that the dened by the detached		Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the u	nderlying cause giver	n in Part I.		23e. Did	tobacco	use contribute	to the cause of death?
of Vital Records,	quires in sign ald be	d by	Dementia							1 🗆	Yes 2	!□ No 3□	Probably 4X Unknown
တ္ထ	law requir as been s 2 should l	Completed							[24a. Was		24b. Were	autopsy findings available o completion of cause of
Ä	The I	E O								perfo	ormed?	death o 1 □ Y	
/ita	ıyslcian: Thı nis certificate director, pag	Be (25. Was case referred to medical examiner?						of Death (C				
£	hysia this o	ဥ	1 ☐ Yes 2 🔯 No				nt 3 DOA Other	4 EN INUI				6 ☐ Other (S	pecify)
Ë	ng fte	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y, Year)	8b. Time o Injury	Work?	at ? ′es 2∐N		. Describe	how inju	iry occurred	
Division	Attending or death. ector: After by the funer	icat	2 Accident investigati 3 Suicide 6 Could not		urv - At hom	ie. farm. str		es 2 🗆 in		Location (Street a	nd Number or	Rural Route Number,
≥	after after Dire	Certification:	4 ☐ Homicide determine	building, et	c. (Specify)	, ,	eet, factory, office			City or To	wn, Stat	re)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		Physician: To the best aminer: On the basis of and manner st	f examination								
	o the vithin of the comple	Mec	29b. Signature and title of certifier		/		29c. License	number			29d. D	ate signed (Mo	nth, Day, Year)
	->-0		1 tralia	13/8/20	2/-	<u>-</u>	DZI	524				FEG 14	2011
	. 0		30. Name and address of person wh	o completed cause of c	leath (Item 2	23a) (Type,							4
	14		Herbert S. B. I	Baraf, M.D.	2730	Univ	ersity Blv	vd., 1	W., #3	10, V	Vhea	ton, Ma	ryland 20902
	Sta Registr		 Date filed (Month, Day, Year) 	32. Registr	ar's Signatu	re							
DHI	MH 17 Rev 1/2	-	ILDAO	2011 Jenn	w x	7. 1	arke		_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of Mary		artment of F rtificate of		F	Reg. Nb.	1	04317	
Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day	Year	3. Time of Death	
/Medic		Claude E Ric			T		Feb		11	2:50P M	
Examin	er	4a. Facility Name (If not institution, give Longview Nurs:				r Location of Death lester	ı		4c. County of Death Carroll		
Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			lace (State or Foreign	
Director			-	6 Yrs.	Months Days	Hours Min.	oct 3	^h 1914	MD Coun	try)	
land ow		10a. State 10b. County	100	: City, Town or Lo	ocation				1	0d. Inside City Limits	
e Mary 3a-f sh	Director	MD Carrol	L		West	minster				1 □Yes 2 ¹ No	
after death with the Marylan items 23a or 28a-f show	ral Dire	100. Street and Number 1606 Littlesto	own Pike		10f. Zip Code	21157		o .	g. Citizen of What Country? USA		
ral",	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □Yes 2🙀 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Bla Specif	ce - Americ ck, White, o y: Whi	te	
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired Huckster	during most of work d)	king	Poult		dustry	
ld be filed v lental Hygic ked other ic event, II	To Be Co	17. Father's Name (First, Middle, Last) George E Rich	nards			18. Mother's Nam	a Bosse		ne)		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, IT and once.		19a. Informant's Name/Relationship (7) Guy B. Stull-F	riend	791	ng Address (Street Redskin	Dr.,We		ter,MD	211	57	
Pages 1 tment of H tant: If iter lury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State -	Krider'		2-1		20c. Location Westmi	nste	r,MD	
permit Depar Import any in		21. Signature of Funeral Service Licens	Flither =		2. Name and Addre						
Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Ceriba	death. Do not en	\sim	ng, such as cardiac Leni Len				Approximate Interval Between Onset and Death	
rtificate be executed ng physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor d.		pie VO	news					
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								ery Day Year	
equires that en signed b	þ	Part II. Other significant conditions of	entributing to death but not	t resulting in the u	underlying cause giv	ven in Part I.		obacco use con Yes 2 ☐ No		ne cause of death?	
: The law re icate has be ; page 2 sho	Completed						24a. Was autop perfo 1 □ Yes	rmed?	prior to co death?	psy findings available mpletion of cause of 2 No	
ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		et all pos Oth	26. Place of Dea					
Phys rat di	٦.	1 ☐ Yes 2 ☑ No 27. Manuner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	III 3 DOA	4 🖾 Nursing H	ome 5 Resid	dence 6 Other		(y)	
ending eath. or: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea		Wor	k?]Yes 2□No	Edd. Describe i	now injury occur			
ital or Atturs after de ral Directo led in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)			City or Tov	vn, State)		al Route Number,	
he Hospi in 24 hou he Funet pletely fill	Medical		/sician: To the best of my Iner: On the basis of exa and manner stated.								
To ti withi To ti	Ž	29b. Signature and title of certifier	Aleton r	. 5	29c. Licens	Se number		29d. Date signed	ed (Month, 3 / 2	Day, Year)	
51		30. Name and address of person who c	ompleted cause of death	688	Print)	d Wa	thin	stur	10 8	11157	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature)					
Registra HMH 17 Rev 1/20		FEB 1 5 2011 🔏	news A.	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William **Brent** Roach 7:47 PM Phryar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death aflata harles Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) i. Social Security Number 294-42-7451 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1**X** M 2 □ F Days Months Hours 09/16/1947 Director 63 Usual Residence of Decedent ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo MD Prince George's Brandywine 1 Yes XX No 10e. Street and Number 10g. Citizen of What Country? Funeral 15975 Meandering Drive 20613 - 4110 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Marines Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1964-68 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic event, th Clerk Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ray Barbara Davis 9a. Informant's Name/Relationship (Type, Print)
Gina L. Carlucci / Spouse 19b. Mailing Address (Street and Number or Rural Route Number, Çity or Town, State, Zip Code) 15975 Meandening Dr., Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name Maryland Cremation Services PO Box 1413, Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Etiysician/ ARDIODU (MONARY disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): ASTROINTESTINA BIRRA Few HRS MASSINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RETROPERITORICAL BIRDLEY 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown RENAL FAILURE, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy KESPIRATURY performed ☐ Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 24 hours after dea Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопретер (Check To the I within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified APPENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVINKUMAR PATEL 102 PAULME HON CT, WALDORF MD 20602 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

			Amend #25 & 27	ase Type or Pri per ME g912 State of M ad #18 Per Fi	nt, in, Blac 2/13/11 aryland / 1	Depar	delible Ink tment of H 72011 JH	ealth a	ure Al and M	II Copies ental Hy	s Are giene	Legibl	e.	01.319
	Physicia	ın/	Registrar 1. Decedent's Name (First, Middle			Certi	ificate of D	eath		2. Date of De	ath	Yea	ır	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution,	n, give street and number)		214.	4b. City, Town, or	Location o				County of De	~	40
	Funeral Director		5. Social Security Number 215–28–1108		e (In yrs. last birt		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs.	8. Date of Birl (Month, Da March 26	th y, Year) 1932	. (Birthpla Country ryla	nce (State or Foreign v)
	aryland ia-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland NA	/A	10c. City, Town	n or Loca							10	d. Inside City Limits 1 XYes 2 No
	with the N 23a or 28 ust be not	Funeral Director	10e. Street and Number 141 North High		<u>. </u>		10f. Zip Code	212	24		10g. Citiz	en of What	Countr	y?
9036	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☒ Marr 3 ☐ Widowed 4 ☐ Divorced	If You Cive	Ever in U.S. No	If Y	as Decedent of His res, specify Cubar	, Mexican,	in? (Spec Puerto R	ify Yes or No- lican, etc.)		4. Race - Ar Black, Wl pecify: W	hite, et	c.
21215-0036	within 72 hou rgiene. her than "nather the Medica	Completed by		nt's Education est grade completed) College (1-4 or 5		(Give kin life. DO l	nt's Usual Occupa nd of work done du NOT use retired) O Worker		of workin	g	16b. Kind of Business Bethlehem			
Maryland	d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, L Alfred Rae	.ast)					r's Name Name	(First, Middle, Hanger Jea	Maiden Su n Mil			
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Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	cemeter	ry, cremat	tion (Name of tory or other place rematory		ebrua 11, :	- 1		ation - City imore		n, State Cyland
Bal	permii Depar Impor any in		21. Signature of Funeral Service Li	futnory Connelly Funeral Home of Dundalk, P.A. 21222										
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	Examiner	ıer	Sequentially list conditions,	b	PAL.			7 094	o reta	100.		1	5	Hours
	executed ian and irial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	с	a consequence o	,	CE	RTIFICATION	APPROVE	D BY MEDICAL E	XAMINER	<i>0</i> 1	+	
8760	eath certificate be attending physici for use as the bu	Medica	IF FEMALE:	d										
). Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. We shall be the bound after death, the certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death		Ectopic pregnancy Other (specify)				23	Month	_	/ ay Year
ds, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant condition	ns contributing to death bu	ut not resulting i	n the und	derlying cause give	n in Part I.						cause of death? bly 4 Dunknown
Division of Vital Records,	ician: The law recertificate has be	Completed										prior t death	o com	y findings available oletion of cause of
tal	clan; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death	n (Check d	only one)	- 700	900		
Ž	Phys r this c ral dir	으	1 Yes 2 No	1 Inpatie	ent 2 ER/Ou v 28b. T	tpatient ime of	3 DOA Other	4 ☐ Nur		ne 5 Resid			ecify)	
ouc .	nding ath. r; Afte e fune	Certificate:	1 Natural 5 Pending 2 Accident Investig		1 (njury 2001	work?	es 2 🔽	<i>,</i> _	losk,B	_ ′ ′		77	LY FELL
/isi	r Atte ter de recto	ertif	3 Suicide 6 Could r 4 Homicide determine	not be	n. At hama for				28	8f. Location (S City or Tow	treet and I		Rural R	oute Number,
ă	oital o		IRI A		(Specify)					Al h.	172011	MND	AV	E BALTTHON
	To the Hospital or Attending Physician: within 24 hours after death. To the Luneral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Ex	Physician: To the best of r xaminer: On the basis of ex Nurse Practioner: To the b	amination and/or	r investiga	ation, in my opinion	, death occ	curred at ti	he time, date a	nd place, a	nd due to th	ne caus	
_	To the within 2 To the Comple		29b. Signature and title of certifier		· ·	cage, aca	29c. License	number				signed (Moi		
			30. Name and address of person w	Who completed assure of the	onth (Itom 202) C	Type D-		135	40		1-121	3 10	-	1005
4	+1		HUGH HILL	MD 49	140 E	N-ST	RRN A	Er	SAL	TIM	ORI	EM	0	21224
	Stat Registra		31. Date filed (Month, Day, Year)	5 2011 32. Registra	r's Signature	God	exel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	/ Department of H Certificate of		Hygiene	04320
	Physic		1. Decedent's Name (First, Middle, Last)	Pudell	de la companie de la companie de la companie de la companie de la companie de la companie de la companie de la	2. Date of Month 2	of Death	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name, (If not institution, give some solution) 10 10 10 10 10 10 10 1	u of Baltin	nore Balt	IMORE CITY	h, Day, Year)	Death Birthplace (State or Foreign Country) aryland
	yland how		10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
	ath with the Marylan 23a or 28e-f show wat be nuffiled at	Director	Md.		Baltimore	City	40-07	X∑XYes 2 □ No
	3a or 3	in in	10e. Street and Number 514 Umbra Stre	et	10f. Zip Code 2 1 2	224	10g. Citizen of Wha	
920	or Items	by Funeral	11. Marital Status 1 丞Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		dispanic Origin? (Specify Yes of an, Mexican, Puerto Rican, etc Specify:	or No- 2.) 14. Race - Black,	American Indian, White, etc. White
21215-0036	n 72 hours "neturel",	Completed	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usual Occup (Give kind of work done life, DO NOT use retired	during most of working	16b. Kind of Busin	ness/Industry
212	77 7 1 1	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Machine Ope	•	Western	Electric
Maryland	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last) Anthony C. Ru	dell	_	18. Mother's Name (First, Mi		
aryla	AS DE LE	J.	19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Street	Margaret and Number or Rural Route N	Parr lumber, City or Town, Sta	ate, Zip Code)
	1 and 2 Health a tem 27 is		James Rudell /	Brother	514 Umbra S	treet Balti	more, Mar	yland21224
nore	ages 1 and of Heat: If item		20a. Method of Disposition 1X Burial 2 Cremation 3 CR	emoval from State	ce of Disposition (Name of netery, crematory or other plac Stanislaus C		20c. Location · Cil	
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	A .	22. Name and Addre	ss of FacilitKaczoro	wski Fune:	
	20 E 6 9		23a. Part1. Enter the disease, or compli	cations that caused the death		dalk Avenue		e, Md.21222 Approximate
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	e artery	disease		Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a conseque) DOMENT	19			
	ted nsit	Examiner	Sequentially list conditions, 1 any, loading to min adjut cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nea of):			
,	ficate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequen	nce of):			1
8760,	physic s the bi	dical						
.O. Box 6	ne death certii the attending thed for use a	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy	/	23d. Date of Month	,
<u>α</u>	sign d be	by	Part II. Other significant conditions con	stributing to death but not resulti	ing in the underlying cause giv			whe to the cause of death? ☐ Probably 4 ☐Unknown
	The law ate has b page 2 sl	Completed					autopsy priode dea	ore autopsy findings available or to completion of cause of ath?
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	P/Outpation: 3CT DOA Oth	26. Place of Death (Check of		
	Attending Physic death. sector: After this by the funeral di	H	1 Yes 2 No 27. Manner eath 1 Latural 5 Pending 2 Accident investigation	1 Impatient 2 EF	8b. Time of Injury Wor	y at 28d. Desc	Residence 6 □ Other stribe how injury occurred	
=	el or Atten s after deal il Director: ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Locat City o	ion (Street and Number or Town, State)	or Rural Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the tir n and/or investigation, in my o	me, date and place, and due to pinion, death occurred at the t	the cause(s) and mann time, date and place, and	er as stated. d due to the cause(s)
)	To th within To th compl	Me	29 . Signature and sittle of certifier	I ma m	29c. Licens		29d. Date signed (/	
			30. Name and a fress of person who d	mpleted cause of death (Item 2:	3a) (Type, Print)	056414 st Belvedere	Ave, Balt	imore, MA
	Sta Registr	100000	31. Date filed (Month, Day, Y + r) FEB 15 2011	32. Pouistrar's Signatur	Wed .	of range	11,001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 10:17 MAM Calvin B. Slaughter February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 🗆 F Year) **Director** 77 224-38-3182 May 02, 1933 or 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1. Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6300 Red Cedar Pl 21209 United States 201 Apt. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 SNo Specify: 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self-Employed <u> Hair Stylist</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy Edward Slaughter Maude Virginia Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Krim /POA 329 E. 29th St. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State cemetery, crematory or other place Feb 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01442 Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ude to (of as a sonsequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: (Month, Day, Year) work? 1 Yes 2 No Natural 5 Pending neral Director; A I filled in by the fi ☐ Accident ☐ Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier February 12, 2011 25205 6+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 15

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 30 per dvr g912 2-15-11 vt State of Maryland / Department of Health and Mental Hygiene, State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STEVENSON Month 0132 HORACE 2011 Medical Feb Examiner 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death renera olumbia toward ounty Howard **Funeral** Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 - F Month, Day, Year) Months Min Country) H6Yrs Director une Usual Residence of Decedent works 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Completed by Funeral Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No olumbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: " 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) /Seconday (0-12) College, (1-4 or 5+) xovernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 venSor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ct Apt Columbia ear 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1 Kridge 4 Donation 5 Other (Specify) 2011 wole Signature of Funeral Service Lo 22. Name and Address of Facility Horne MD 20190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, loading to himmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of, The law requires that the death certificate be executed bunial-trans Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month been signed by the s should be detached to Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate 2 P No 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Division of Vital 25. Was case referred to medical director. 26. Place of Death (Check only one) examiner? 1 Yes Other: R/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 29b. Signature and title 29d. Date signed (Month, Day, Year) D6910 Feb 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Samit Desai 5755 Cedar Lane Columbia, Md. 21044 31. Date filed (Month, Day, Year) State 32. Registrar s FEB 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Februan 10:00 AM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Forest 1+1more 8. Date of Birth 5. Social Security Number Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. If Under Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🖫 Months Hours Min Yrs. Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more ti more 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be Funeral Forest 2120 "natural", or item edical Examiner n 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT, use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be traumatic event, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Page 1 and 2 should be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. urdavant alto 3611 MO Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MKL 12011 attimore 4 Donation 5 Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility MEDD Home Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car fac or respiratory arrest, shock, or heart failure. List only one cause on each lin Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day 2 12 No 1 Urknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an has autopsy performed? Yes 2 2 No certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Hospital: 1 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred I Director; After d in by the funer 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the test of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2.

To the F 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2114 D3/322 201 9

Registrar

State

1 RANDEEP

31. Date filed (Month, Day, Year)

716

MAIDEN CHOICE IN, BALTIMORE, MIZIZZZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A4)

32. Registrar's Signature

GARG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Fibruary 3:06 **Physician** 201 Trange /Medical 4c. County of Death 4a. Facility Name Uf not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □XM 2 □ F 53 213-70-0566 05-16-57 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 1719 Aberdeen Road Apt."B" USA 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 11. Marital Status ¹X Never Married 2 ☐ Married 1 ☐ Yes Ž No Baltimore, Maryland 21215-0036 Specify Specify: American Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Prep-Cook Airport 12th Grade traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Baldwin Catherine Theodore Shaw ည 19a. Informant's Name/Relationship (Type. Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Shaw Baldwin Department of Health a Important: If item 27 is any injury or other trainonce. 120-12 195th Street St. Albans, NY 11412 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial Cremation 3 Removal from State 02-11-11 Catonsville, Metro Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, shock, or heart failure. List, one cause on each line Immediate Cause (Final **Physician** apres disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to mine diatacause. Enter Underlying Cause (Disease or injury that initiated events dificile pan-colitis The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? has 2 🗌 No 2 No 1 Tyes After this certificate 25. Was case referred to medical 26. Place of Death Che k onl one) Attending Physician; funeral director, Be examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Inpatient 1 Tes 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 Yes 2 No s after death. the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 🗌 Homicide City or Town, State) 10 To the Hospital o within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only one) Commedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

Emily Brigham Johns Hopkins Hosp. 600 North Wolfe St, Baltimore, MD, 21287 2

State Registrar 31. Date filed (Month, Day, Year) FEB 1 5 2011

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, c, perFH, G913, 3/4/2011, WS

State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day)eloves February 9 9:45 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Medical Cente Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 - M 2 F Months Days Hours Min Director 10a. State 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore MD 1 🂢 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give mith-Matthews, Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Suri ပ္ Informant's Name/Belationship (Type, Print ral Route N<u>umb</u>er, s (Street and Numbe perr it. Page 1 and 2 sh
Dep rtment of Health ar
Important: If item 27 is
any njury or other trau racey 4780 A) aughter 20a. Method of Disposition Place of Disposition (Name of Location - City or Town, State
Lansdowne / Maryland 3/4/2011 1 Burial 2 Cremation 3 Removal from State chretery, Zrenomy or other place) 4 Dopati Other (Specify) 1905 York, Road 21. Signature of Funeral Sen 22. Name and Address of acility 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate , or heart failure. List only one cause on each line. Interval Between immediate Cause (Final Onset and Death Physician/ Sensis Syndrone disease or condition 5 days Medical resulting in death) Due to (or a consequence of): Examiner 5days Staph Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Protein Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Calerie Malnutriho Physician: The law requires that the death certificate be executed lyear and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Unknown the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Carchda Esophagin's page 2 should be 1 🗆 Yes 2 🗆 No 3 🗔 Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate Yes 2 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 DANO Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide work?
1 Yes 2 No injury 5 Pending Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Connel Cohen mo 2/10/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOAME Cohen MO 6701 North Charles Street Bulf more MD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 Registrar FEB

DHMH 17 Rev 7/2009

11-01088 Katherine Erin She	don Please Type or Print in Black Indelible State of Maryland / Department			011 0432				
	1- For State Certificate Certificate		Reg. No.					
Physician/ Medical Examine		n	2. Date of Death Month Day February 8, 2011	Year 3. Time of Death 1115 hrs				
	Facility Name (if not institution, give street and number) 18020 Chalet Drive Apartment 302	4b. City, Town, or Location of Deat Germantown		unty of Death tgomery				
Funeral Director	5. Social Security Number 220-98-0812 1 M 2 X 1 29 Y	20 Months Days Hours Min. T. 12 1002						
and show any nee,	Usual Residence of Decedent 10a. State	ntgomery 10c. City, Town or Location Germantown						
tith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 18020 Chalet Drive #302	10f. Zip Code 20874	10g. Citizen 0	of What Country?				
or items : must be		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto Yes 2XX No specify:		Race - American Indian, Black, White, etc. White				
11215-0036 Id be filed within 72 hours after Aental Hygiene. arriced other than "natural", event, the Medical Examines De Completed by	Elementary/Secondary (0-12) 12 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) +2 Par	ent's Usual Occupation (Give kind of most of working life. DO NOT use rel	ired)	of Business/Industry				
21215-0036 uld be filed within? Mental Hygiene. marked other than c event, the Medica. To Be Comple	17. Father's Name (First, Middle, Last) Albert T. Sheldon, PHD	Mada	e (First, Middle, Maiden Surr alyn Wahalen	,				
MD 2121 d 2 should be fil th and Mental I n 27 is marked umatic event, To Be		ng Address (Street and Number or E. Colony Shore Dr.	Rural Route Number, City or Cypress, Tx	Town, State, Zip Code) 77433				
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and In Important: If item 27 is us injury or other traumatic	1 Burial 2 Cremation 3 XX Removal from State Crematory or Memorial 0	aks Cemetery 2/19	9/11 Houst	tion - City or Town, State				
	Thehologent 36	Name and Address of Facility 1rgee—Henss—Seitz Fund 31 Falls Road <u>Bal</u> to	, MD 21211					
Physician /Medical :xaminer	23a. Part I. Enter the disease, or com lications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Heroin and Ethanol Due to (or as a consequence of):		or respiratory arrest, shock, o	or heart Approximate Interval Between Onset and Death				
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death). Last							
xecuted n and I - transit	events resulting in death) Last d. X UNPENDED AMENDED AMENDED AMENDED AMENDED AMENDED AMENDED	.28a-f per me g91	2 2-23-11 vt					
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transference of the funeral or the funeral director or	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregnature (Specify)	23d. Da	te of delivery th Day Year				
S, P.O. I uires that the n signed by the detached	Part II. Other significant conditions contributing to death but not resulting in the Cocaine Use	underlying cause given in Part I.	1 Yes 2 No	contribute to the cause of death? 3 Probably 4 V Unknown 4b. Were autopsy findings available				
Division of Vital Records, P.O. tal or Atteoding Physician: The law requires that the rs after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	25 Was case referred to medical	26 Place of Death (Check	autopsy performed? 1 ✓ Yes 2 No	prior to completion of cause of death? 1 Yes 2 No				
Vital hysician this cert	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	nt 3 DOA Other Nursin	ng Home 5 Residence					
Sion of Vatteoding Ph. r death. cctor: After ti by the funeral cation: Te	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Fd 2-8-11 Fd 11:	1 Yes 2 X No	28d. Describe how injury of unknown	ccurred				
Division To the Hospital or Atteod within 24 hours after death To the Funeral Director: completely filled in by the Hollong Certificati	3 Suicide 6 X Could not be determined (Specify) found at hor	eet, factory, office building, etc.	Germantown,					
To the Ho within 24 To the Fu completel	Check only Check only 2 Medical Examiner: On the basis of examination and/or investig and manner stated.							
T A F S	29b. Signature and title of certifier Pollum Pollum	29c. License number O.C.M.E.		signed (Month, Day,Year) y 9, 2011				
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	900 W. Baltimore Street, E	Baltimore, MD 21223					

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM// Derphys, G912, 2/24/2011, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Veronica Colleen Stebbings 2. Date of Death 3. Time of Death Year Month **Physician** Veronica Collene Stebbings 0802AM 201 Feb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A St. Agnes Hospital Bultimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 8, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1942 Days 1 □ M 2 🗓 F 68 Maryland 219-40-7199 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County in than "natural", or items 23a or 28a-f show the Medical Examination of the restitled at 1 XYes 2 No Director N/ABaltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3630 Clarenell Road 21229 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 📉 No White Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within 7 of Health and Mental Hygiene. item 27 is marked other than "n other traumatic event, It a Med Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Margaret Deibert Henry Karcher ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3630 Clarenell Rd., Baltimore, MD 21229 Gilbert R. Stebbings - Husband permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 1 🔀 urial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2-17-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Am rose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to humodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-transit 6 the attending physician and hed for use as the burial-trar Due to (or as a consequence of) 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Year burs after death. eral Director: After this certificate has been signed by the sifiled in by the funeral director, page 2 should be detached if 5 Other (specify) Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy The performed Division of Vital 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \) To the Hospital o within 24 hours af To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DAMMICAN, M.D. P23612 Feb 13,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 900 (aton Avenue, Baltimore, MD - 21229

Registrar DHMH 17 Rev 1/2001

State

DURGA DHOJ ADHIKARI

32. Registrar's Signature

Green

ERONTH

11-01005 Richard Neil Smith	h	Pie		pe or Print tate of Mary								_egib		1	1 00
		I - For State Registrar						f Death				Reg. N	40. <u>CU</u>	1	1432
Physician Medical Examine	er	Decedent's Nam		Richard		Nei1	S	mith			2. Date of Month Februa		2011 y Year 010		3. Time of Death 1452 hrs
1		4a. Facility Name (811 St. Geo		on, give street and r	number)			4b. City, Town Edgewood		ocation of Dea	th		4c. County of D Harford	eath	
Funeral Director		5. Social Security N	Number	6. Sex]	e (In yrs. last bi	rthday) Yrs	If Under 1 Months [If Under 24H Hours M.	in	,	h (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD		
any	-	Usual Residence o 10a. State	f Decedent 10b. County		-	10c. City. Tow	or Locat	ion						_	10d. Inside City Limits
	-	MD		imore		Too. Oxy, Town	Tor Eood			Dunda	1 k			- 1	1 Yes 2 No
the Maryland or 28a-f show tiffed at once.	25	10e. Street and Nu		Linore				10f. Zip Cod	е	201144		10g. 0	Citizen of What	Count	ry?
th the 23a or notifie	5		hwood						222				United		
er death with the r. or items 23a		11. Marital Status 1 X Never Marrie	ed 2 M	arried Armed	Forces?	Ever in U.S.	13. Wa	is Decedent of es, specify Cu	Hispa ban, I	anic Origin? (\$ Mexican, Puer	Specify Yes or to Rican, etc.)	No-	14. Race - A White, e		an Indian, Black,
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21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (Last) d Smith,	Tr				18	3.Mother's Nam	e (First, Midd				
		19a. Informant's Na	me/Relations			19	9b. Mailing 239 A	Address (St	reet a	and Number or		Number,	City or Town, S		Zip Code)
ore, MC	1	20a. Method of Disp		n 3 Removal	from Stol		of Dispos tory or oth	ition (Name of	ceme	etery,	Date	200	c. Location - Cit	y or T	own, State
Baltimore, permit. Pages 1 ar Department of Hea Proportant: If iter injury or other tr		4 Donation 5	Other Sp	pecify:	TOTAL STATE			rvice	Cor	cp. 2/	10/201	1 T	owson,	Ma:	ryland
Balt permit. Depart port injury	ľ	21. Sig ture of Fur	neral Servi	cens	1	0	Dt	lame and Addr 1da-Ruc	k 1	Funera1	Home	of I	oundalk,	, I	nc. 1222
Physician	+	Page Enter the failure. List onl	e di ease, or	complications that	caused t	he death Lon	ot enter th	922 Wisne mode of dying	ng, su	Ave. I uch as cardiac	Oundalk or respiratory	arrest, s	aryland hock, or heart	$\frac{1}{1}$	Approximate Interval
/Medical Examiner		Immediate Cause (For condition resulting	Final disease	a. Narc		(Morpl	nine)	Intox	ica	tion					Between Onset and Death
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ficate be ex g physician the burial	-	F FEMALE:		23c. If yes,		of pregnancy		— —	пс	g)12 2	-13-11		3d. Date of deli	verv	
68 certifi	2:	3b. Was decedent p past 12 months 1 Yes 2 N	?	1 Live	birth nant at ti	of do-att		al death :	3	Ectopic pregn	ancy		Month	Da	y Y ear
hat the dered by the addrached for	h	Part II. Other signif		9 000		but not resultin	a in the u	nderlying caus	e aive	en in Part I.	23e. Die	d tobacc	o use contribute	to th	e cause of death?
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Reco	L										pe 1 ✓ Ye	rformed? s 2	P death No 1 ✔		2 No
n of Vital Rec Ling Physician: The I After this certificate b funeral director, page on: To Be Com		5. Was case referre examiner?	_	Hospital:	Inpatient	2 EB/0	utpatient			Death (Check		7.5	dence 6 🗸 0	the same C	
of Vi		1 ✓ Yes 2 7. Manner of Death	No No	28a. Date		28b.	Time of Ir			at Work?	ng Home 5		njury occurred	iner: S	ocene
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he Hosp n 24 ho he Fune oletely f	- 1 /			ysician: To the be	st of my l	knowledge, dea	ath occurr				due to the ca	iuse(s) a	and manner as	stated.	
To the He within 24 To the Fe completel	2	9b. Signature and to		niner: On the basis and manners	stated.			29c. Lice			at the time, da		. Date signed (
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	Anthony 4a. Facility Name (if not institution, g	give street and number)		Sapp 4b. City, Town, or L	ocation of Death		4c. County of D	Death		
	Bon Secours Hospital	, ,		Baltimore						
Funeral	Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Bir	th (MM/DD/YYYY) 9). Birthplace (State or		
Director	214-80-3022	Xm 2 F 49	Yrs	Months Days	Hours Min.	07 0	6 61 F	oreign Country) MD		
	Usual Residence of Decedent	Zi'' 201 45				10.				
Á	10a. State 10b. County	10c. City	, Town or Locat	ion				10d. Inside City Limits		
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th the Maryland 13a or 28a-f sho notified at once al Director	900 Mt. Holly	Street		212	29		U.S.A.			
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72 hours 12 hours 12 Exami	15. Decedent's Education (Specity	15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)								
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21215-0036 ould be filed within 7 d Mental Hygiene. a marked other than ite event, the Medica TO Be Comple	Rayford Sapp 19a. Informant's Name/Relationship	(Type Print)	19b Mailing	Address (Street	ena Bl	ural Route Num	ber, City or Town, S	State Zin Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Department of Health and Mental Hygient and sturral?, or items 23a or 28a-f she injury by other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director				•				, Md 21229		
and 2 lealth tem 2	Lena Sapp-Moth 20a. Method of Disposition	20b.	Place of Dispos	ition (Name of ceme	etery,	Date	20c. Location - Cit	ty or Town, State		
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Baltimore, permit. Pages I an Department of He Impertant: If ite	4 Donation 5 Other Speci 21 Signature of Funeral Service/Lic		22 1	lame and Address of	of Facility	12 <u>/201</u>	1 Woodl	awn, Md		
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ox 6876C eath certificate at attending phys for use as the bh	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	ath -	tal death 3	Ectopic pregnar	псу	Month	Day Year		
Box 6 te death ce the attend the attend ted for use	1 Yes 2 No 9 Unknow		5 Ot	her (Specify)						
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signed libe deta						1 Yes	2 V No 3	Probably 4 Unknown		
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tal Rection: The certificate ector, page		·		00 PI	(D	1 ✔ Yes	2 No 1 🗸	Yes 2 No		
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nding Ph nding Ph th. : After i e funeral	1 V Natural 5 Pending	(Month, Day, Year)			s 2 No					
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Division o spital or Attending ours after death. The filled in by the fure Certification:	3 Suicide 6 Could no determin	ot be				or Town, S	tate)			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 bours after death. To the Punearal Director: After this certificate has been signed by the attending phys completely filled in by the finneral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me		clan: To the best of my knowled	ge, death occur	red at the time, date	and place, and	due to the caus	e(s) and manner as	stated.		
To the Howithin 24 P. To the Full completely	one) 2 Medical Examin	er:On the basis of examination a and manner stated.	-							
To wit	29b. Signature and title of certifier	and memor stated.		29c. License	number		29d. Date signed	(Month, Day, Year)		
	Mayora Day	Knell		O.C.M	.E.		February 6, 2	011		
2	30. Name and address of person wh	o completed cause of death (Item	1 23a)				l			
		Assistant Medical Examír		. Baltimore Stre	eet, Baltimore	e, MD 2122	3			
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire backs	1						

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Jas	on Lon Stineba	1	- For State	Si	tate of Ma	aryland		irtment d <i>tificate d</i>			l Mental	Hygiene	Reg. N			14.231
Мe	Physiciar dical Examin	1	Registrar 1. Decedent's	Name (First, Midd	lle,Last) J	ason	Lo	on S	Stine	bau	gh	2. Date of Month Februa	Death	/ Yea	-	3. Time of Death 1438 hrs
				me (if not institution Baltimore Sti	_	and number	-)		4b. City, To Dunda		ocation of De			4c. County o Baltimore		
	Funeral Director		5. Social Secu 212-0	rity Number 6-4713	6. Sex		ge (In yrs. la 36	ast birthday) Yı	If Unde Months		If Under 24 Hours	Hrs. 8. Date o			Foreign	hplace (State or n untry) Montana
6	e Maryland r 28a-f show any led at once.	5	10a. State MD 10e. Street and			ore :		Town or Loca	10f. Zip		Balti 24	more	10g. C	itizen of Wh	at Coun	-
8.0/	or death with 1	- L	11. Marital Sta 1 Never M	Married 2 N	larried Ar	ates:			erto Rican, etc.) White, e Specify:			, etc.	White			
\	036 ithin 72 hours: ne. r than "natur: fedical Exami	Compresed		s Education (Specondary (0-12)		est grade co lege (1-4 or		16a. Decede during	nost of work	ing life.	DO NOT use	of work done retired)		Ser	viness/li	
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	50	17. Father's Na Greg	ame (First, Middle Ory Lo	n Sti	neba	ugh			1		en Lyn		surname) Keist	er	
	MD 21, d 2 should b th and Men a 27 is mar numatic eve	o l'	19a. Informant Karen	's Name/Relations	ship (Type, Prii inebau	igh/M	othe	19b. Mailii	ng Address Bur	(Street	and Number de Dr	or Rural Route ive, E	Number, Bel	City or Town Air,	n, State, MD	Zip Code) 21015
	Baltimore, I bernit. Pages I and Department of Healt Important: If item injury or other training.		4 Donatio	2 XCrematio	pecify:		tate F	rematory or of the Linal Jo	ther place) OUTNEY	cre	em. 2/	Date /16/2011	1 V	o. Location - Voodbi	ne,	MD
	Balt permit. Departt Import injury	٩Ţ	51 20	of Funeral Service	- Xvai	la.	U		PO	Bo≥	1413	3, Bal	timo	re,	MD2	1203
	Physician \/Medical		failure. Li	ter the disease, or st only one cause	on each line.							ac or respiratory		hock, or hea	art	Approximate Interval Between Onset and Death
	Examiner			use (Final disease sulting in death)		or as a cons			TEUATO	aLI	JI. G C.	Cuinc	abe		-	
		_	Sequentially li	st conditions,	b			٤١٠					_			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

	<u>n</u>
	Medical Certification: To Be Completed by Physician/Medical Examine
completely inted in by the futieral unected, page 2 should be detacted for use as the buriar - training	ñ
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4 Donation 3 Other Speci			
21. Signature of Funeral Service Lic	ensee Doro a Mars all 22 Name and Address of Facility Maryland Cremation	Services	
(1) proto H.	Markay PO Box 1413, Balti	more, MD2	203
failure. List only one cause on	nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an each line.		Approximate Interval Between Onset and Death
	a. Narcotic (Heroin) intoxication & cocaine us	e	
or condition resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions,	b		
f any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):		
Disease or injury that initiated	c		
events resulting in death) Last	Due to (or as a consequence of):	5	
	d		
UNPENDED	AMEN9EP,27,28a-f,per ME g913 3/3/11 TT		
F FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delivery	
3b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Da	ay Year
1 Yes 2 No 9 Unkno	4 Pregnant at time of death 5 Other (Specify)		
Tes 2 No 9 Olkio	9 Onknown		
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did t	obacco use contribute to th	ne cause of death?
	1 Ye	s 2 No 3 Proba	ably 4 🗹 Unknown
	24a. Was		opsy findings available
	auto	ormed? prior to co	mpletion of cause of
	1 ✓ Yes		2 No
25. Was case referred to medical	26.Place of Death (Check only one)		
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other:	Scene
27. Manner of Death		how injury occurred	
1 Natural 5 Pending	fd 2/10/11 fd 2:30 pm 1 Yes 2 X No unk		
2 Accident Investig	ation Fu Z/10/11 Tu Z.Jo pill	Street and Number or Run	al Bouto Number City
3 Suicide 6 X Could n	ot be or Town,	State) 7851 E. B	altimore st
4 Homicide determine	ned (Specify) Id residence Dundall	, MD	
29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau	se(s) and manner as state	d.
one) 2 Medical Examin	ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date	and place, and due to the	cause(s)
Oh Ciacture and title of partition	and manner stated.	T 29d Date signed (Mon	th Day Year)

O.C.M.E.

February 11, 2011

State Registrar DHMH 17 Rev 1/2001 OCME 2006

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Laron Locke MD.

31. Date filed (Month, Day, Year) FEB 1 4 2011

ne and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 elen Tilahman 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore NI Hospital Baltimore Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 8 7 Yrs. 9. Birthplace (State or Foreign Country) If Under 24 Hrs. Funeral 1 □ M 2 X F Min. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits with the Maryland Director Baltimore 28a-f MD Baltimore 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r by Funeral 6825 Campfield USA Road, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 27 is marked other than "natural", or ite traumatic event, the Medical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 13 ack 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
US CIVIL SERVICE (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Staffina Special ist Commission 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ scar Newton Page 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ludgate Road Baltimore MD Department of Health Important: If item 27 ea Newton NIECE injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 02/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licensee Vaugun C. Ereene Puneral Selvices 22. Name and Address of Facility Loaz fandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) respiratory day Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN 2 **X**No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Mnpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 2 Accident
3 Spice 5 Pendina 2 🗌 No Investigation within 24 hours at er death

To the Funeral Director: A 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature title of 29c. License number 29d. Date signed (Month, Day, Year) -000 person who completed cause of death (Item 23a) (Type, Print) Garcia

DHMH 17 Rev 7/2009

State Registrar

Helen

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

		1- For State Registrar	e of Maryland /	•	ent of Hea ate of Dea		, ,	2 0 1 Reg. No.	1 433
Physici Medical Exam		Decedent's Name (First, Middle, L Marcus, Bon	ast) ito Trevino	2			2. Date of De Month	Day Year	3. Time of Death 1635 hrs
parame.		4a. Facility Name (if not institution, g			4b. City,	Town, or Location	February of Death	4c. County of De	
		12308 St. James Road			Poto			Montgomen	
Funeral Director		453-94-0259	X M 2 F 7. Age	(In yrs. last birt	hday) If Und Monti		s Min	3/1951	Birthplace (State or reign Country) Texas
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			···	10d. Inside City Limits
E	or	Maryland Montg	omery		Potomac				1 Yes 2 X No
h the Maryl 3a or 28a-i	Director	10e. Street and Number 12308 St. Jame	s Road		10f. Zij	20854		10g. Citizen of What C	· ·
1215-0036 Id be filed within 72 hours after death with the Maryland Vental Hygiene. narked other than "natural", or items 23a or 28s-f show event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marrie	1 Yes 2	Ever in U.S.	If Yes, spec	fy Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	White, etc	
urs afte	d by	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates: only highest grade com	pleted) 16a. [Decedent's Usual	Occupation (Give	Mexican kind of work done	Specify: I ^{VI} 16b. Kind of Busines	exican ss/Industry
036 tithin 72 ho are. or than "na	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	(+)	during most of wo	rking life. DO NOT	use retired) Enginner	N.I.H./C	·
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Las Benito Trevin	*			1	's Name (First, Middle,	Maiden Surname)	
212 212 2uld be 1 Mente 1 mark ic even	To B	19a. Informant's Name/Relationship		19b	. Mailing Address		y Jinez nber or Rural Route Nu	mber, City or Town, Sta	ate, Zip Code)
MD at 2 sho atth and m 27 is		Lisa Trevino	(Wife)			oft Court		kville, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specif			f Disposition (Na ory or other place		Date Feb. 11,	20c. Location - City Port Arth	·
Balt permit. Depart Import injury		21. Signature of Funeral Service Lice	A Moosou	_	22 Name and Burgee	Address of Facility	itz Funera	al Home, In	ic.
Physician	\mathcal{A}	23a. Part I. Enter the disease, or coor	plications that caused t	he death. Do no	1 3631 F t enter the mode	alls Rd. of dying, such as c	Baltimore, ardiac or respiratory ar	Maryland rest, shock, or heart	Approximate Interval
/Medical Examiner	1	failure. List only one cause on a Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		ohol abuse				Between Onset and Death
	5	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of);					-
	Medical Examiner	name Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	ruance of):					
cuted nd transit	Ä	events resulting in death) Last	1	querica or).					
60, ate be executed hysician and e burial - transit	dica	UNPENDED	AMENDED			_			
68760, certificate be nding physici se as the buri	Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		Fetal death	3 Ectopic	pregnancy	23d. Date of deliver	ery Day Year
atter or u	Physician/	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at t	ime of death 5	Other (Spe		, pregnancy	Month	Day real
P.O. Best hat the degree by the	b P	Part II. Other significant conditions	contributing to death	but not resulting	in the underlying	cause given in Pa		obacco use contribute	_
ords, F w requires is been sign should be	ted						24a. Was	222	obably 4 Unknown autopsy findings available
of Vital Records, g Physician: The law requir ther this certificate has been si neral director, page 2 should t	Completed			<u> </u>			auto	psy prior to prior to death?	completion of cause of
	Becc	25. Was case referred to medical		-		26.Place of Death (1 Yes (Check only one)	2 No 1	Yes 2 No
of Vital ing Physician: After this certif	잂	1 ✓ Yes 2 No	Hospital: 1 Inpatien			OA Other		Residence 6 🗸 Ott	er: Scene
ਵਰੀ ੂੈ ਵੀ		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Ye	y 28b. T ar)	ime of Injury	28c. Injury at Work	1	how injury occurred	
Division pital or Attendi ours after death real Director;	Certification	2 Accident Investiga 3 Suicide 6 Could no determine	28e. Place of Inju	ıry - At home, far	m, street, factory	office building, etc	c. 28f. Location (or Town, \$		Rural Route Number, City
Divisio To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	29a. Certifier 1 CertifyIng Physic (Check only one) 2 Medical Examine	rian: To the best of my r:On the basis of exam and manner stated.						
	ŽΓ	29b. Signature and title of certifier	, ,C	1	290	License number		29d. Date signed (M	
	-	30. Name and address of person who	constant.	Ath (Hom Co.)	^	O.C.M.E.		February 9, 201	1
V			istant Medical Exa		W. Baltimor	e Street, Baltir	more, MD 21223		
Sta Regist	_	31. Date filed (Month, Day, Year) FEB 15 2011	32. Registrar	Signature			-		
	_		Russer Co	grano					····

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Blanca Tidemand Physician/ Month 4:15 P February 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 11, 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 218-40-0570 92 **Director** Denmark Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Lutherville 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1414 Front Avenue 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White "natural". 3 ₩Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Megone. Elementary/Seconday (0-12) College (1-4 or 5+) Bendix Radio Assembly Line permit. Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Hans Petersen Joergine FEBRUARY 10, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lone Azola (Daughter) 1097 West Lake Avenue Balto, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 Transfer 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory or othe 2/14/2011 Glen Burnie, MD Signature of Frmeral Service Lines 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home 3631 Falls Road Balto, MD 212. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No atte Month Dav Other (specify) Pregnant at time of death 1 ☐ Yes ∠∠ 9 ☐ Unknown 9 Unknown detached completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No TIDEMAND 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No 24 hours after death Funeral Director: A 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 TIMONIUM MD ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD 31. Date filed (Month, Day, Year, 32, Registrar's Signature State 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20a b. per FH G912 2/15/2011 WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°11 2:30 A Harold Rogers Taliaferro Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore CO. 9826 Clanford Rd. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Sex 1 💆 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours 1 277077 1947 Virginia Director 214-54-4949 63 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 200. any injury or other traumatic event, the Madian-10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 XNo Randallstown Baltimore co. MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 U.S.A. 9826 Clanford Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian þ 1

Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beth St. 12th Grade Line Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Susie Brown Charles Taliaferro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21219 7222 Orth Rd., Lue Farmer(sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date On-site Crematory Garrison Fores 4 ☐ Donation 5 ☐ Other (Specify) Forest 02/04/11 Baltimore, MD 21. Signature of Funeral Service Licens Joseph Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician (andr disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury the Hospital or Attending Physician; The law requires that the death certificate be execute ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant Other (specify) Pregnant at time of death n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 🗌 Yes 2 \No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: within 24 hours are...

To the Funeral Director: After trus... မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🛮 Residence 6 🗆 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Iniurv at 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OWE 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimure VId

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

2. Registrar's Signature

			Please Type or Print AMEND TTE State of Ma	M#7,8 per	INF, G912, 2/18/20 Dartment of Health and	of Mental Hy	s Are Legible. giene	
5		•	For State State Registrar		ertificate of Death		Reg. No.	04335
oma	Physicia Medic		1. Decedent's Name (First, Middle, Last) Hortense Carro	011	Thomas	2. Date of De Month	ath Day Year	3. Time of Death 1 6:02 P M
2	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of De	eath C'IV	c. County of Deat	1
F	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24 h	rs. 8. Date of Birt	4 / 1 2 / 1929 9. Birt	hplace (State or Foreign
17	Director		212-28-0078 1 M 27 F Usual Residence of Decedent	86 81 Yrs.	Months Days Hours M	lin. (Month, Da	2 24 Col	MD_
N 1	land show d at	tor	10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits
ens.	e Mary r 28a-f notifie	Direc	MD NA 10e. Street and Number	Balt	imore			1 X Yes 2 □ No
0	with th	Funeral Director	4403 Wentworth Road		10f. Zip Code 21207		10g. Citizen of What Co	-
7	death		11 Marital Status 12. Was Decedent Ev	er in U.S. 13.	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
40	s after ral", or Exami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ N 1 ☐ Yes 2 ☒ N 1 ☐ Yes Give Year or Dates.	lo	1 ☐ Yes 2 No Specify:			lack
15-0	2 hour "natul edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation a kind of work done during most of t	vorking	16b. Kind of Business	ndustry
252	within 7 giene. er than the M		Elementary/Seconday (0-12) College (1-4 or 5+ 12th grade 2yrs	·) life. l	00 NOT use retired) Nurse		Providenc	e Hospital
2 pur	e filed vital Hyg	To Be	17. Father's Name (First, Middle, Last)	•	18. Mother's	Name (First, Middle,	Maiden Surname)	•
25 Iryla	should be file n and Mental h 7 is marked o raumatic eve	-	Charles Carroll 19a. Informant's Name/Relationship (Type, Print)	10b Mai	Ing Address (Street and Number or	E. Robin		Cadal
⊬ηιωη vre, Maryla	nd 2 sh salth ar n 27 is er trau		Katherine Oakes-Daughte		Oella Ave, E			
\sim	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State		ematory or other place)	Date	20c. Location - City or	
き	mit. Pa partmer portant rinjury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Meadow		14/2011	Elkridge,	Ма
Patient Baltim	permit Depar Impor any in	(1)	Tale Mara	/ M 4	22. Name and Address of Facility arch F/H West 300 Wabash Av	e, Balti	imore, Md	21215
	Dhuaisian/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		disease or condition resulting in death) a. Due to (or as a	CONSEQUENCE Of):	iai Hemori	nage	-	laay
	Examiner	er	Sequentially list conditions, b. 5+1	OKL				lday
a.	uted	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	, , , , , , , , , , , , , , , , , , , ,			- 3	111
Mo	be executed sician and burial-transit	cal E	resulting in death) Last Due to (or as a	consequence of):				
68760	ficate by g physi as the t	Jedic	d					
39 ×	th certii ttendin or use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome o	Petal death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
Box	the dea y the ar	Physician/Medi	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death 5	Other (specify)		WORR	Day Isu
, P.O.	res that the death certificate signed by the attending phys be detached for use as the		Part II. Other significant conditions contributing to death bu	-	underlying cause given in Part I.		obacco use contribute to	
ords	requi been should	leted	Hypertensian Hyperlipidemia			1 🗆	,	obably 4 Unknown opsy findings available
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tal	ician: 1 certifica ector, p	Be	25. Was case referred to medical examiner?		26. Place of Death (C			7
of V	g Phys er this eral dir	e: To	27. Manner Death 28a. Date of injury	nt 2 ER/Outpatie	ent 3 □ DOA		dence 6 Other (Speci now injury occurred	fy)
ion	tending leath. tor; Aft the fun	Certificate:	1		work? 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	al or At s after o l Direct d in by		4 Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	treet, factory, office	28f. Location (S City or Tow	Street and Number or Rur vn, State)	al Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of example) Additionally one) Certifying Nurse Practioner: To the basis of example (Check only one) The basis of example (Check only one)	amination and/or inve	stigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the o	ause(s) and manner stated.
	To th withi To th		29b. Signature and title of certifier Andrea Ahern,		29c. License number		29d. Date signed (Month	, Day, Year)
	3		30. Name and address of person who completed cause of dea		- 4		1112	# X
	Stat	te.	Antonia Ahern, mp 31. Date filed (Month, Day, Year) 82. Registrar	Sina 's Signature	i Hospital	ot 13a	1+1more	
	Registra	-	FEB 15 2011 Comma	A. Dan	Kel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,20a-c per fh 9912 2-22-11 vt. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Antoinette R. Tubman 02 2011 7:59p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3019 Ferndale Ave Baltimore 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M **%**□ F Months Days Hours Min. (Month, Day, Year) 213-62-7337^{km} Director 19 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ death with the Maryland Director notified 1 Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be 23a Funeral 3019 Ferndale Ave 21207 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married "natural", or þ within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 ☐ Widowed 4 😾 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade 2yrs Private Duty Caretaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Tubman Margaret Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3019 Ferndale Ave, Antonio Tubman-Nephew Baltimore, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Off Streematory or other place) 2-16-11^{Ukn} T Sourial 2 S Cremation 3 Removal from State Baltimore Memorial Donation 5 C Other (Specify) rbutus Arbutus, Md 21. Si mati e of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death as Physician/ disease or condition resulting in death) Medical Due to (or as nsequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death signed by the a d be detached for 2 🗌 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the case of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) Manne 28a. Date of injury (Month, Day, Year) eath 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Injury 5 Pending Natural after death. 1 Yes 2 No M Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTOMP 2/2/1 F Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ John W. Townes 11:00 A February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2419 ANNAPOLIS RD. BALTIMORE 8. Date of Birth (Month, Day, Year, OCT 8 1 5. Social Security Number Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Hours NORTH CAROLINA 1925 Director 241-42-0894 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10c. City, Town or Location Director 1 X Yes 2 □ No BALTIMORE MARYLAND N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 2419 ANNAPOLIS RD. 21230 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ST, JOE PAPER CO 6th grade MACHINE OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PLUMMER TOWNES LILLIA CLAUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2419 Annapolis Rd., Baltimore, Maryland 21230 Lula B. Townes/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ZION CEMETERY 02-15-2011 LANSDOWNE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COM
1206 W NORTH AVENUE COMMUNITY FUNERAL HOME PA. elaleur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final End-Stage Parkinsons Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funera Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 1 L/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

MSRay up rumeM · D 29d. Date signed (Month, Day, Year) 2/10/11 00057465 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

N.S. Rajapaksemo

2835 SMIM N-5-203/

32. Registrar's Signature

Baltimore, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 10,2011 12:55P.[™] Tully Martha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May8,1920 9. Birthplace State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Maryland **Director** 90 214-18**-**0469 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 ☐ Yes 2 1 No Baltimore Timonium Md. 10e. Street and Number 2300 Dulaney Valley Road 10f. Zip Code 10g, Citizen of What Country? 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 ☐ Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th Owner/Operator Convenient Store Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Tully Katherine Piechocka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1906 Andrea Court Finksburg, Md. 21048 Cynthia Turnes / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Stanislaus Cem. 15,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Nome, P.A. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of wing, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Tue to (or as a consequence of) Examiner Sequentially list conditions. Examine Date to the estat consequence off cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes 2/L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director; After this certificate has autopsy performed? ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 🄀 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one

State Registrar

EBRUARY

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

and title of certifie

ERNESTINE WRIGHT, M.D.

License number

2300 DULANEY VALLEY ROAD

29d. Date signed (Month, Day, Year,

TIMONIUM

21093

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Feb. 1:32 Physician/ Donald М VanDeusen 9, Medical Le Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ፟ M 2 ☐ F Months Days Hours (Month, Day, Yea 6/6/1934 218-30-2504 76 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director MD Montgomery Gaithersburg 1 🗌 Yes 2 🛭 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9528 Watkins Road 20882 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2XXMarried 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Electronics Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everett Keller VanDeusen Dorothy Virginia Kirn ပ permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic t injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9528 Watkins Road Gaithersburg, MD 20882 Roberta VanDeusen, wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State 02-15-11 Chesapeake Crematory Beltsville, MD 4 Donation 5 Other (Specify) 21. Sign at re Juneral Service Livinse M01539 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Airway obstruction by food bolus disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer ENTIFICATION APPROVED BY WESTON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Day 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No Yes 2x XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? ☐ Natural 5 Pending choked while eating 2 📉 No 2/7/2011 5:00 2X Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home 28f. Location (Street and Number of Bural Route Number City or Town, State) 9528 Watkins Rd. Gaithersburg, MD 20882 determined

31. Date filed (Month, Day, Year) FEB 1 5 2011

30. Name and address of person who completed Ndidi B. F. Feinberg,

29b. Signature and title of certifie

29a. Certifier

32. Registrar's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gause of death (Item 23a) (Type, Print) MD; 11165 Stratfield Court, Marriottsville, MD 21104

29d. Date signed (Month, Day, Year)

February 12, 2011

29c. License number

D0059423

3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201^{Year} Physician/ Margot Karla Vobe p_M 2:40 Feb. Medical 4a. Facility Name (if not institution, give street and number) 4b. Citý, Town, or Location of Death Silver Spring 4c. County of Death Montgomery Examiner Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Countrie ermany 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 10/31/1925 218-56-3577 1 M 2xxF 85 Director Usual Residence of Decedent 28a-f shov 10a. State MD 10b. County 10c. City, Town or Location Silver Spring 10d. Inside City Limits Examiner must be notified at Directo Montgomery 1 Yes 2 No 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8144 Hartford Avenue 20910 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 5 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 . Page 1 and 2 should be filed within 72 hours aftr ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International Investing Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Ehleben Helena Romer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8144 Hartford Ave. Silver Spring, MD 20910 Michele E. Vobe, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 2/11/2011 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Beltsville, MD 4 Donation 5 Other (Specify) MO1539 21. Signature of Funeral Service License 22. Name and Address of FacilityRapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ days Medical resulting in death) Due to (or as a consequence of): Examiner days Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Thrombosis Records, 1 Yes 2 No 3 Probably 4x Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XXNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 02/7/2011 29c. License number D333332 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sukresh K Gupta; 9801 Georgia Ave. Ste 220 Silver Spring, MD 20902

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

FEB 1 5 2011

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32. Registrar's Signature

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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	/			23d. Date of deliver Month	very Day Year
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To the composition of the compos	-	29b. Signature and title of certifier 30. Name and address of person who composite of the	noll is	ın	29c. License	number 50 (612	29d. D	ate signed (Month,	Day, Year)
15		30. Name and address of person who comp	oleted cause of death (Item.	23a) (Type, F	eirs Dr	rive	Rockuil	1/e	Marylon	d 20850
Stat Registra	ė	31. Date filed (Month, Day, Year) FEB 1 5 2011	Registrar's Signatu	bar	الما		•			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walls 2135 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey House Baltimore If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month 1 1 1 - 1 9 5 2 VA 230-74-5421 Director 59 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature". 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 1110 Darley Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Disabled
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Disabled Elementary/Seconday (0-12) College (1-4 or 5+) vrs Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter David White, Angie Virginia Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, Md 21218 110 Darley Avenue <u> Alberta Sample-Sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 2-15-2011 Lansdown, MD Donation 5 Other (Specify) March East F/H 21. Signature of Fune al Service Li 22. Name and Address of Facility Balto, MD 21202 Meles 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 sl autopsy performed Yes 2 2 🗆 No certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Tes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2011 **Physician** 1:37.4 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) JULY 30, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 XX **GERMANY** 63 Director 214. 56.1682 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD ANNE ARUNDEL LINTHICUM HEIGHTS 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 215 HOMEWOOD RD. 21090 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 🐰 🗙 No If Yes, Give Year or Dates þ 3 Widowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR MVA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN WILSON MOORE CONCETTA ROSSI ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RON WELDON HUSBAND 215 HOMEWOOD RD. LINTHICUM HEIGHTS MD 21090 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pages 1
Department of H
Important: If iter
any Injury or oth 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS CEMETERY FEB 16, 2011 BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility
FINK FUNERAL HOME, P.A 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1 shock or y one cause on each line immediate Cause (Final disease or condition resulting in death) **Physician** Brotin herniation /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No this certificate 1 Yes 2 🗌 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No မ 2 ER/Outpatient 3 DOA 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

8 State Registrar

Sheng

31. Date-filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D

RES-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2011 11:40 PM Gladys Marie Wyre Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 3617 Dublin Road Darlington 5. Social Security Numbe 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, 1 🗆 M 2 🔀 F Months Davs Hours 1924 **Director** 196-16-9813 Pennsylvania 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21034 3617 Dublin Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Margaret Zeigler should be Reuben S. Shenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 3617 Dublin Road, Darlington, Maryland 21034 Richard Wyre / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 10 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 2/16/2011 Bel Air, Maryland Domation 5 🗆 🕅 ther (Specify) Air Memorial Gdn. Sign re of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. Broadway, Bel Air, Maryalnd 21014 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ -NROME Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 1 Tyes Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 140 Hospital 1 Tes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and tit 29c. License number on who completed cause of death (Item 23a) (Type, Print) Balhmore, MD Stemmers Run RD. State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Maryland	/ Depa	artment of Hea	alth and M	1ental Hy	giene		
		1 - State Registrar	Cer	tificate of De	ath		Reg. No.		4345
Physicia	n/	1. Decedent's Name (First, Middle, Last)	T-1-			2. Date of Dea	ath Pay 2 X	3.	Time of Death
Medic Examin		Clarence WH 1 4a. Facility Name (if not institution, give street and number)	1 6	4b. City, Town, or Loc	cation of Death	rev	4c. County of	Death	t - F IVI
Examin	er	Seasons Hospice		Baltimo			N/A		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I		If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birt	h g	l. Birthplace	(State or Foreign
Director		213-52-4691 1 AM 2 F 62	Yrs.			0 11/11 0	/1949 M	lary1	and
and show dat	tor	10a. State 10b. County 10c. City, To	own or Loc	ation	_			10d. lr	nside City Limits
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fter de f, or it	by	1 ☐ Never Married 2 ☐ Married		Yes, specify Cuban, M		Rican, etc.)	Black, V	White, etc.	,
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and 3 Certifying Nurse Practioner: To the best of my knowledge on the control of the	d/or investi	gation, in my opinion, d	leath occurred at	the time, date ar	nd place, and due to	the cause(s)	and manner stated.
To the vithing to the congression of the congressio		29b. Signature and title of certifier	F. 4	29c. License nur	mber	7	29d. Date signed (M		
141	-	30. Name and address of person who completed cause of death (Item 23a	a) (Type P	W/>	8/0	2	reb 8	1 6	1061
5		30. Name and address of person who completed cause of death (nem 202)	Avi	Eghan.	Blood	54	The A	12	1061
Stat Registra	e	31. Date filed (Month, Day, Year) 22. Registrar's Signature FEB 1 5 2011	,						
DHMH 17 Rev 7/20		FEB 1 5 2011 Senter A	gar						

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The within 24 hours atter death. To the Funeral Director: A completely

State Registrar

29b. Signature and title of certifier

CHRISTOPHER 31. Date filed (Month, Day, Year) FEB 15 2

SCIORTI 82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#9perFH, G913,3/9/2011 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\frac{20^{4}}{13}$, 20^{6} February Physician/ 3:20 P ^M Faith Louise Wiley Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Arden Courts Pikesville Pikesville 9. Birthplace (State or Foreign Country) **Maryland**
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day Dec.
 21
 Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral Year] 920 1 M 2 XF Months Director 90 213-28-6637 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 V No MD Baltimore Pikesville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral USA 8909 Reisterstown Road 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 A&P Grocery Store Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Wolfkill Frances Louise Reyer Jewell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Morgan Pkwy, Zebulon North Carolina 27597 Bonnie Harris-Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery Feb. 16,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home Inc. . Signature of Funeral Service License 22. Name and Address of Facility 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final URONAR Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine TE SIDN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) DEMENT To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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Division of Vital Records, P.O. Box 68760 🕂
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
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		For State	State of Mary			ate of Death	,	20		61.21.0
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should and N is ma		19a. Informant's Name/Relationship		19b. Mai	ling Addre	ss (Street and Number or Ru			State, Zip Co	ode)
nd 2 sealth m 27		Nathaniel Ross	s=Son	15 W	alla	ville Lane,	_ Avond	ala. Þ	д 19	311
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permit. Page 1 and 2 should be filed within 72 hours afti. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagonee.		21. Signature of Funeral Service Lice	nsee	1.1	Marc	and Address of Facility h F/H West				
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To the Hospital or Attending Physician; The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical Exar	ysician: To the best of my kn niner: On the basis of examina	tion and/or inve	stigation, i	n my opinion, death occurred a	at the time, date ar	d place, and due	e to the caus	e(s) and manner stated.
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٠.		NIRA ROOPNAK	UNESINGH	MBBS	5	SINAL HOSPIT	PL OF	BACTI	nore	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Woodland 09 20a Medical 02 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard <u>Columbi</u> 10131 Goodbody Ct If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2√ F Days Hours Min. (Month, Day, Year) Director 216-28-3955 81 3 iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia MD Howard 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21044 U.S.A. 10131 Goodbody Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry
Baltimore City (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools 5+yrs Guidance Counselor 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Avis Woody Edward Chism 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pimlico Road, Baltimore, Md 21209 Beth Woodland Hargrove 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 2/17/2011 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ pancreatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 **X**No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executer Division of Vital Records, P.O. Box 68760 ours afer death.

eral Director: After this certificate has filled in by the funeral director, page 2: within 24 hours a To the Funeral D

State

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person

Zheng

31. Date filed (Month, Day, Year) FEB 15

6 Could not be

determined

600 N.

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64552

Baltimore, MD 21287

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

Street

who completed cause of death (Item 23a) (Type, Print)

te

Registrar's Signature

Wol

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February,

10,2011

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O. Box 6
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 **Physician** 17:58 M E. Wilson Sr. February Harold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPILA Itimure (SINAI 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 □ F Months Days Min. **Director** 220-28-1803 77 28 MD Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov Director 1 ▼Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2725 North Rosedale Street 21216 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Evanther mone. any Injury or other traumatic event, the Medical Evanther rauguse. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs Supervisor US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Wilson <u>Bertha Hadrick</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type. Print) Lucille Wilson-Wife 20a. Method of Disposition 2725 North Roesdale Street, Baltimore, e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 2/16/2011 Owings Mills, Md 21. Signature of Funeral Service Licenses 1arch F/H West ola 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) herosclerotic Hear Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): ng physician and as the burial-transit Exami Due to (or as a consequence of) Physician/Medical signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed peen RIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2.8 autopsy performed 1 ☐ Yes 2 🖎 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) nK MI EDER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 5 Registrar

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	For State Registrar			ertificat					Reg. No	201	1 04351
	1. Decedent's Name (First, Middle, La	st)						2. Date of D	eath		3. Time of Death
Physician/ Medical	EARTIS WEST	Eartis Mae	West					Februa	Da	04 20	0527 AM
Examiner	4a. Facility Name (if not institution, give UNION MEMORIAL				4b. City, Town, or Location of Death BALTIMORE				40	N/A	Death
Funeral Director	5. Social Security Number 6. S 216–20–5863	Sex 7. Age ☐ M 2 🖾 F	e (In yrs. last birthda 86 Yrs	Months Days Hours Min -/			8. Date of Bi	rth 924 ar)	9. N	Birthplace (State or Foreign CAROLINA	
r ow	Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town or	Location							10d. Inside City Limits
he Maryland or 28a-f sho s notified at Director	MD. N/A		BALTIM								1 Yes 2 No
with the 1 23a or 2 1st be no	10e. Street and Number 1928 E. LAFAYET	TE AVE.		10f. Zip	Code 2121.	3				itizen of What	t Country?
leath with the terms 23a cer must be	11. Marital Status	12. Was Decedent 8	ever in U.S. 1	3. Was Deced			gin? (Spe	cify Yes or No	-	14. Race - A	american Indian,
P 2.9	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	If Yes, spec				Rican, etc.)			hite, etc. BLACK
5-0 ? hour "natu dical	15. Decedent's E (Specify only highest gr	Education rade completed)	16a. De	cedent's Usua ve kind of wo	al Occupa	ation	t of workir	na	16b. k	Kind of Busine	ess Industry
Baltimore, Maryland 21215-0036 bermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exampance.	Elementary/Seconday (0-12)	College (1-4 or 5 -2-	i+) life	. DO NOT use CLERK		army mod		·9	ВО	ARD OF	EDUCATION
land 2 be filed v lental Hyg rked othe itic event,	17. Father's Name (First, Middle, Last) GEORGE W. WALKE	ER						(First, Middle E • GOO		Surname)	
ary chould and M is mai	19a. Informant's Name/Relationship (1	Type, Print)	19b. M	ailing Address	(Street a	and Numbe	er or Rurai	Route Numb	er, City o	r Town, State	, Zip Code)
nd 2 s ealth a m 27 i	ANDREW WEST (SON	1)	22	CHEV	ERLY	CIRC	LE C	HEVERL	Y, M	ARYLAN	D 20785
more age 1 ar age 1 ar ent of H or: If iter	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	20b. Place of Discemetery, of DULANEY	rematory or o	ther plac	e) M		eate -2011	1		y or Town, State MARYLAND
Baltir permit. P Departm Importar any injur	21. Signal in Juneral Service Liden	TOTAL PRITTING	D. HIBNE	R _{2. Name an}	d Addres	s of Facilit	PHIL	LIPS F	UNER	AL HOM	E, P.A. RÝLAND 21217
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Physician/	shock or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line Hupp	Dixo								Interval Between Onset and Death
Medical Examiner	resulting in death)	Due to let ask	consequence of):								1 hour
ı.Ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Due to (or as a consequence of): Cerebral Vascular Accident mont							1 month			
⊒ ∃ 	resulting in death) Last		a consequence of):								
68760 entificate bending physical base as the k	IF FEMALE:	d							T		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burit. Medical Certificate: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3		y				23d. Date of Month	f delivery Day Year
S, P.6 S, P.6 ires that to a signed book details detai	23e. Did tobacco use contribute to the cause of the										
Records, The law requires cate has been signage 2 should t								24a. Was	psy	prior	e autopsy findings available to completion of cause of h?
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fital sician: certific irector, irector,	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 ER/Outpa		100	ace of Dea				0 0 011 /0	
of Vi	27. Manner of Death	28a. Date of inju	ry 28b. Time	of 2	8c. Injury	/ at		me_5 ∟ Hes 28d. Describe		6 ☐ Other (S ry occurred	pecify)
On on earth. Fr. Afte	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigatio		(, Yea <i>r</i>) injur	M	work	? Yes 2□	No				
Division of Vital Recolotial or Attending Physician: The law rest after death. Indirector: After this certificate has bed in by the funeral director, page 2 start Certificate: To Be Comple	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		iry - At home, farm, :. (Specify)	street, factory	, office		1	28f. Location City or To			Rural Route Number,
Le Hospita in 24 hours ne Funeral pleted filled	(Check 2 Medical Exam	rsician: To the best of iner: On the basis of ex se Practioner: To the	kamination and/or in	estigation, in	my opinic	n, death o	ccurred at	the time, date	and place	e, and due to t	the cause(s) and manner state
within vithin comp	29b. Signature and title of certifier	/	best of my knowledg			number	запа расс	s, and due to t			onth, Day, Year)
	I flood K	, ,	MD	Ĩ	000	533	73		Fenn	vary 0	4 2011
(l_0)	30. Name and address of person who Paul Kans		eath (Item 23a) (Type Memoria		pital	7	Balt	more	MD		
State Registrar	31. Date filed (Month, Day, Year)		tr's Signature	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 240 OPHELIA G. WALLACE Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death 4c. County of Death Examiner N/A Maryland Genera Ctimore Social Security Number 1 Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 41-210-14-92-15 MARYTAND 215-24-8131 81 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ▼ Yes 2 No N/ABALTIMORE MD. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral 21217 USA 1932 WALBROOK AVE. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Completed by 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes If Yes, Give 1 Yes 2 No Specify. Specify: BLACK 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) NURSING ASSISTANT HEALTHCARE -12--0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ STEVELLA PARKER LEONARD WALLACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE. JOHN WALLACE(SON) FALKIRK RD. MARYLAND 21239 20a. Method of Dispositio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Crei ation 3 Removal from State ARBUTUS MEMORIAL PARK 2-17-2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Signat Funeral Service License 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line.

Immediat Cause (Final Onset and Death Physician/ eumoc disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) g 🗌 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural (Month, Day, Year) 5 Pending work' 1 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 10/

Registrar

State

32. Registrar's Sig

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			State	of Maryland / Depa			/lental Hyg	giene	1 1	SLOTO	
			Registrar	Cer	tificate of E	Death		Reg. No.	-	44303	
	Physicia	n/	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of Death	
	Medic		Rose Marie Zurek 4a. Facility Name (if not institution, give street and n	4h City Tours or	Location of Death	Febru	aryl0,	201	Ll 11:30A [™]		
وميد	Examin	er	812 South Port Stre	17	4c. Count	y or Death					
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth	n .		place (State or Foreign	
	Director		216-32-6515 1 M 2 🕸	75 Yrs.	Months Days	Hours Min.	(Month, Day	1935	Man	vland	
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	he Ma or 28	ä	10e. Street and Number		10f. Zip Code		T	10a. Citizen of	What Cou	ntrv?	
	with th	Funeral	812 South Port Stre	et	212	24		U.S.A		,	
	eath v	E E	11. Marital Status 12. Was De	ecedent Ever in U.S. 13. V	Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Rad	ce - Ameri	can Indian,	
တ္တ	fter d , or i	ğ	1 Never Married 2 Married 1 7 Yes	s 2 17 No	f Yes, specify Cubar □ Yes 2 □xNo		нсап, етс.)		ck, White,		
21215-0036	tural'	Completed	3 - Widowed 4 - Divorced Year or	Dates.				Specify		nite	
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פ	filed valued by all Hyg	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, i	Maiden Surnam	re)		
Maryland	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	욘	Walter Zurek			Mary B	aracki				
Ja	shou n and ris m raum	E)	19a. Informant's Name/Relationship (Type, Print)	- 1	ng Address (Street a						
_	ge 1 and 2 it of Health if item 27 or other tr		Mrs. Ann Gaither /	Sister 1230	Delber						
Baltimore,	Page 1 nent of ant: If it		1 Burial 2 ☐ Cremation 3 ☐ Removal fro	om State cemetery, cren	natory or other place		ruary	20c. Location			
	permit. Page Department Important: II any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		islaus					Maryland Home, P.A.	
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			23a. Part 1. Enter the disease, or complications the	at caused the death. Do not ente						Approximate	
	Physician/		shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	Bulls Malia	4 44 4 4 17	Polici I	alader	en.		Interval Between Onset and Death	
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л Э	at the	, Ph	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?	
ς, Τ	signe d be	Completed by	Coverey artery Disease, H	y parterson, Si	Dum S	Joursis,	1 🗆 1	′es 2 □ No	3 🗌 Pro	bably 4 2 Unknown	
Vital Records,	requ been shoul	lete		it los + Delyclation					24b. Were autopsy findings available		
ပ္ပို မ	ne law e has age 2	omp	7,000	agains			autop perfor	med?	death?	or to completion of cause of ath?	
E .	an: Th tificat tor, pa	Be C	25. Was case referred to medical		26. Pla	ace of Death (Chec	1 \(\superstack Yes\) k only one)	2 X No	1 L Yes	2 🗆 No	
	nysici iis cer direc	To E	examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpatien	nt 3 🗆 DOA Othe	er: 4 🗀 Nursing Ho	ome 5 🔀 Resid	ence 6 🗆 Oth	er (Specif	······································	
0	ng Pł fter th	ite:	27. Manner of Death 28a. Da 1 X Natural 5 Pending	te of injury 28b. Time of injury injury	28c. Injury work	at	28d. Describe ho				
0	tendi death. tor: A the fu	Certificate:	2 Accident Investigation			Yes 2 No					
DIVISION OF	or At after d Direct in by	Cert	4 Demiside determined 28e. Pla	ce of Injury - At home, farm, stre Iding, etc. (Specify)	eet, factory, office	J.		n (Street and Number or Rural Route Number, Town, State)			
ב	spital	ical	29a. Certifier 1 Certifying Physician: To the	best of my knowledge, death of	occured at the time,	date and place, ar	nd due to the cau	se(s) and manr	ner as state	ed.	
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in the underlying cause givent that time of death but not resulting in the underlying cause givent that time of death but not resulting in the underlying cause givent that time of death but not resulting in the underlying cause givent that time of death but not resulting in the underlying cause givent that time of death but not resulting in the underlying cause givent that time of death but not resulting in the underlying cause givent that time of death but not resulting in the underlying cause given that time of death but not resulting in the underlying cause given that time of death but not resulting in the underlying cause given that time of death but not resulting in the underlying cause given that time of death but							t the time, date ar	and place, and due to the cause(s) and manner stated			
_	To t To td		29b. Signature and title of certifier		29c. License	number	29d. Date signed (Mon			Day, Year)	
			R.T. Febru	Jus.	D 2	1464	1	Februa	ry 1	4, 2011	
			30. Name and address of person who completed ca			C+	D - 1 · *		M.1	01007	
	Stat	e.	Dr. Robert T. Liber 31. Date filed (Month, Day, Year) 32.	Registrar's Signature	oo bank	Street	Dalt1	more,	· DIY	<u> </u>	
	Registra		FEB 1 5 2011) A hove							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ William Bernard Bremen Februa 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** toro De Grac Harre en 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Sex 1 M 2 □ F 0 1 / 20 / Min. Hours 93 217-26-5756 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 XYes 2 □ No Harford Maryland Aberdeen 10g. Citizen of What Country? 10e. Street and Number Of. Zip Code ò event, the Medical Examiner must be Funeral 21001 23a 704 Webb St. or items 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WV 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. WWII Completed by 1 Never Married 2 Married X Yes Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀No Specify. "natural", 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Civil Service and Mental Hygie is marked other æ 17. Father's Name (First, Middle, Last) should be filed 18. Mother's Name (First, Middle, Maiden Surname) Catherine McCarthy John Bremen other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10835~Woodhaven~Dr, Fairfax, VA 2203019a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kathleen Swiatek/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem Gardens 2/19/2011 Aberdeen 4 Donation 5 Other (Specify) 21. Signature Fureral S Relic 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P
333 S. Parke St, Aberdeen, MD ron Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part 1 Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner r m Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury death certificate be executed g physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical MK men, Willam Division of Vital Records, P.O. Box 68760 IF FEMALE: Jse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy atter for u in the past 12 months? Day Month Year Pregnant at time of death 2 🗌 No a Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has a funeral director, page 2 s autopsy performed^a 1 🗆 Yes 1 🗌 Yes 26. Place of Death Check only one) Be 25. Was case referred to examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mayor of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10111 of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Y M Medical County of Death Name (if not institution, give stre Town, or Location of Death **Examiner** Hinore 8. Date of Birth (Month, Day, rs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Vrs **Director** dence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have acted as a superstant of the state of the st 10c. City, Town or Location 10d. Inside City Limits 10b. County Completed by Funeral Director 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status ed Forces? Yes 2 No Are Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Security ocial Elementary/Seconday (0-12) College.(1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ oman Informant's Name/Relationship (Type, Print) (Sx) 19b. Mailing Address (Street and Number or Rural Route Number, Cit for Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place M Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) . Sign an re of Funeral Service License 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ meu disease or condition resulting in death) Medical Medicai Examiner Due (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Use to (or self-considering of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 16

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bai Month Physician/ 11:55 AM ohn leu February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins Baltimore Bayview Medical Center 1 Year If Under 24 Hrs. 9. Birthplace Country) 7. Age (In yrs. last birthday) 30 Yrs. If Under 8. Date of Birth State or Foreign Funeral 1 M M 2 □ F Hours Min. Director or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No timor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygient and Important: If item 27 is marked other than "natural", or items 23a, Important: If item 27 is marked other than "natural", or items 23a, any injury or other traumatic event, the Medical Examiner must be Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No 3 Widowed 4 Divorced 10 Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College 1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden S 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License al Home orti 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, Familia Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 VUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 2 12 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 Natural injury 5 Pending Accident Investigation **Director:** 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Bach MD. 4940 S Christopher 21224 Eastern MI) Avenue 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 16 20 DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc g912 2-16-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2011 1415pm January 31 Kim Ladonna Booth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PG Cheverly Prince George's Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Months Days 579-04-4191 45 11/28/1965 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Event in the public of the profiled at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1XYes 2 No PG Forestville MD Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20747 6007 Rose Bay Drive Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify Specify: Black δ 3 ☐ Widowed X☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline E. Regins Andre Haggins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6007 Rose Bay Drive; Forestville, MD 20747 Marquita L. Booth-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/9/2011 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Sign dury of Funeral Service License 4594 Beech Road; Temple Hills, MD 20748 23a. Pari 1. E ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat O use (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 🌣 🛣 No Month Day 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying Division of Vital Records, ۵ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an certificate has page 2 autops 1 ☐Yes 2 Ø No React of Death (Check only one) director Be examiner' Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this After thi funeral 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injur 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09:44a M February MARY CLAIREECE BRICE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD CO UPPER CHESAPEAKE HOSPITAL BELAIR If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2XXF Days MARYLAND Hours (Month, Day, Year) AUG 3 1927 83 Yrs. Director 212-26-1577 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2XXNo MARYLAND HARFORD CO JOPPA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 U.S.A. 607 A. DEMBYTOWN RD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Yes XX No Specify. Specify: BLACK 3XXWidowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ARCH ASSC. FOR RETARED 12th grade Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file
Department of Health and Mental H
Important: If item 27 is marked oil
any injury or other trans. 18. Mother's Name (First, Middle, Maiden Surname) JAMES THURSTON MARGARET THURSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Abdulrahman/Daughter 607 A. Dembytown Rd., Joppa, Md., 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State GARRISON FOREST 02 - 22 - 11OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P..A.
321 S PHILA, BLVD, ABERDEEN, MD 21001 21. Signature Miller 23a. Pad 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Intracerebral disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner malianan Semintially list or notitions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No of Vital the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending Division 2 🗌 No Investigation

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Gertifier 29d. Date signed (Month, Day, Year) D63420 14,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr., Belair, Md., 21014 Zubair Kharal, MD., 31. Date filed (Month, Day, Year) 32. Egistrar's Signature State Registrar

DHMH 17 Rev 7/2009

		Please Type or Print in E							
		1- State of Maryland State of Maryland	-	rtment of F		d Mental H	ygiene Reg. Ne	2 1 1 1 1	04359
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) EVELYM 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	Br	Yart 4b. City, Town, or Baltimore	City		Day 1 4c.	County of Death	
Funeral Director		5. Social Security Number 219-12-5006 G. Sex 1 M 2 F 7. Age (In yrs. le support 1 M 2 F 93	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E (Month, I	Day, Year)	Cot	hplace (State or Foreign intry) MD
Maryland a-f show fied at	ctor	10a. State 10b. County 10c. City	Town or Local						10d. Inside City Limits 1 Yes 2 No
h with the 23a or 28 st be noti	Funeral Director	10e. Street and Number 3325 Kenyon Avenue		10f. Zip-Code 212	13	·	10g. Cit	izen of What Cou A	untry?
s after death , or Items 2 aminer mus	by Funer	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2√ No	ispanic Origin an, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Amer Black, White	e, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Sth grade College (1-4 or 5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done DO NOT use retired OMEMAKE	during most of ()	f working		Gind of Business/	
l be filed w ntal Hygier ed other th event, the	Be	17. Father's Name (First, Middle, Last) John W. Palmer	11	Omemake	18. Mother's	a Durha	ile, Maidei		1.
nd 2 should Ith and Mer 27 is marke traumatic	욘	19a Informant's Name/Relationship (Type Print) Daughte Doretha A. Haskins-		ng Address (Street	and Number	or Rural Route Nur			Zip Code) 21224
Pages 1 annent of Heal		20a. Method of Disposition 11 Disposition 3 □ Removal from State	emetery, cren	sition (Name of natory or other place n Fores			1 Ow		Town, State
permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	1		North	March Avenue	Ва		D 21202
Physician /Medical Examiner		23a. Part 1. Enter the essease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	erot					rase	Approximate Interval Between Onset and Death
ecuted and I-transit	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen							
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 21 No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	y		_	23d. Date of de Month	livery Day Year
uires that the signed by	þ	Part II. Other significant conditions contributing to death but not res	ulting in the u	ınderlying cause g	iven in Part I.			use contribute to	o the cause of death?
The law req tte has been page 2 shou	Completed						topsy rformed?	prior to death?	utopsy findings available completion of cause of
ysiclan: The law s certificate has b director, page 2 s	To Be (25. Was case referred to medical examiner? 1 X Yes 2 \sum No Hospital: 1 \sum Inpatient 2 X	ER/Outpatien	t 3 🗆 DOA Oth	or.	f Death (Check onlying Home 5 - Re		6 ☐ Other (Spe	cify)
To the Hospital or Attending Physician: The Iswithin 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ertification:	00 Date of lating of Donath 200 Describe how injury							
tal or Atters as after de al Directo	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At ho building, etc. (Specify	·)			City or 1	Town, State	e) 	tural Route Number,
he Hospi in 24 hou he Funer ipletely fil	edical	29a. Certifier (check only one) 1 Certifying Physician: To the best of my know and manner: On the basis of examination and manner stated.		vestigation, in my	opinion, death		ne, date ar	nd place, and du	ue to the cause(s)
To the with com	Σ	29b. Signature and title of certifier		29c. Licens	e number	200		ate signed (Mont	
HV		30. Name and address of person who completed cause of death (Iter	n 23a) (Type,						ore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year) FEB 16 2011 Server	D. A	all I				-,	,,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Page State Of Pag		rtificate of Dea		ntai nygie Reg.	2011	04360
	Physicia		1. Decedent's Name (First, Middle, Last) Robert Joseph Be	eatty Sr.			Date of Death Month bruary	Day Year 10, 2011	3. Time of Death 12:15 p ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number		4b. City, Town, or Loca	ation of Death	bruary	4c. County of Deat	h
	Funeral Director		2007 Whistler Ave 5. Social Security Number 6. Sex 7. A 217 30 2864 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Age (In yrs. last birthday) 72 Yrs.			Date of Birth (Month, Day, Ye.	9. Bir	more City thplace (State or Foreign
		Director	Usual Residence of Decedent 10a. State 10b. County Md N/A	10c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the Ma 23a or 28a ast be notif	Funeral Dire	10e. Street and Number 2007 Whistler Ave		10f. Zip Code 21230		10g	. Citizen of What Co	
036	is filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	ed by Fun	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Deceden Armed Forces 1 ☒ Yes 2 [If Yes, Give Year or Dates.	_ No	Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 ☒ No Sp		Yes or No- an, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	vithin 72 hou iene. ir than "natu the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 7th College (1-4 o	r 5+) (Give life. D	edent's Usual Occupation Is kind of work done during DO NOT use retired) Tuck Driver	n g most of working	16	b. Kind of Business Trucking	
land ?	2 should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last) Joseph W	illiam Beat		Mother's Name (Fit		den Surname) nia Walken	r
	age 1 and 2 should be snt of Health and Ments nt: If item 27 is marked y or other traumatic e		19a. Informant's Name/Relationship (Type, Print) Margaret Beatty / Wife		ing Address (Street and A 7 Whistler <i>A</i>				code) ryland 21230
Baltimore,	G F E L		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	Glen Hav	matory or other place) ven Mem. Par		/2011		ie, Maryland
Rail	permit. Departr Importa any inji		21. Signature of Funeral Service Licensea	25	2. Name and Address of 4001 Ritchie	Facility Gonce e Hgwy. E	e Funera Baltimor	1 Service e, Md. 21	24B.A. 225
+	hysician Medical	20 (2	23a. Part 1. Enter the disease, or complications that case shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition resulting in death)	ine.	ter the mode of dying, sur			NOWN	Approximate Interval Between Onset and Death
- A	Examiner	ڀ	Sequentially list conditions b.	s a consequence of):			PRIMA	4×Y	*
ر	cuted ind transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence of):					
09/	icate be executed j physician and is the burial-transi	edical E	resulting in death) Last Due to (or a d	s a consequence oi).					
2/89	certificat nding ph use as th		IF FEMALE: 23c. If yes, outcom		7			23d. Date of de	livery
). Box 68	the death certif by the attending ached for use a	Physician/N	in the past 12 months?		Ectopic pregnancy Other (specify)			Month	Day Year
ds, P.O.	law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death	but not resulting in the o	underlying cause given in	n Part I.			o the cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed					24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of s 2 12 No
VItal	ysician: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inperior	atient 2 ER/Outpatie	Other:	of Death (Check on		e 6 ☐ Other (Spec	ify)
on ot	anding Phath.	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of in (Month, D		28b. Time of 28c. Injury at 28d. Describe how injury occurred				
DIVISI	tal or Atter safter de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of 1 building, 4	njury - At home, farm, str etc. <i>(Specify)</i>	reet, factory, office	28f.	Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	the Hosp thin 24 hou the Funer mpleted fill	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best only one) 3 Certifying Nurse Practioner: To the control of	examination and/or invest	stigation, in my opinion, de death occurred at the time	eath occurred at the e, date and place, a	time, date and p	lace, and due to the ise(s) and manner as	cause(s) and manner stated. stated.
			29b. Signature and title of certifier		29c. License nun 0006 5	86 (29d.	Februar	y 10,2011
	107		30. Name and address of person who completed cause of HASAN AWAN 2.71	death (Item 23a) (Type, I THAMMON	Print) LAS FERR	Y RD	BALTI	NORE,	mD 2(2)7
	Stat Registra		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	7			•	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. Day Year Physician/ 6:20 PM Gertrude F. Blevins 2011 Medical 4b. City, Town, or Location of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore City Union Memorial Hospital 8. Date of Birth (Month, Day, Year) November 12 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1939 Maryland 218 36 4433 Director Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f show 10b. County 10c. City. Town or Location is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Merical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Baltimore County Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 21234 USA 8807 Fearne Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗎 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping~ Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Finger 17. Father's Name (First, Middle, Last) Harry Matschulat ೭ and 2 should b Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 8807 Fearne Avenue Batimore, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Daniel Blevins (Husband) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a, Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. February 18 2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Dicensee ²²LassanhAfunerai Home Inc. 7401 Belair Road Baltimore Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner (prona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown signed by the ar g 🗌 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ္ဝ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier AT243 89 46 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital SARABCHI FARDAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 6 2011 backs Registrar

11-01201 Elvis Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician. Month Day February 12, 2011 Medical Examiner 1228 hrs ELVIS BROWN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore N/A5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Funeral Foreign Country)NEW JERSEY Days Min. Months Hours Director 219-52-6116 10-10-1949 1X M 2 F 61 Yrs Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No other than "natural", or items 23a or 28a-f show the Medical Exminer must be notified at once. N/A BALTIMORE MD. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country 1932 DRUID HILL AVE. 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2 X No Yes 3 Widowed If Yes, Give Year 4 Divorced Yes 2 No specify Specify: BLACK Ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 -12--0-CLERK GOLF COURSE of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be traumatic event, JAMES EDWARD BROWN MARIE CALLAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Impurtant: If item 27 is injury nr other traumati BROWN (DAUGHTER) 1932 DRUID HILL AVE. BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 2 X Cg crematory or other place) Buria CREMATORY Other Specify METRO 2-22-2011 Do ation 5 BALTIMORE, MARYLAND HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. MAHTANOT 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ure. List only one cause on each line een Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED the attending physician led for use as the burial **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Á</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown diabetes Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Pending the 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after 3 Could not be Suicide or Town, State) determined To the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ca 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 14, 2011 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Menth, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#7perfng state of Maryland / Department of Health and Mental Hygiene 1 - For a State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Vear **Physician** 14:30PM WELDON E. BRADBY Feb /Medical 201 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes
5. Social Security Number Baltimore N/A HOSPIFAL If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 9-1-8 **Funeral** Months Min Days 92-83-91 VIRGINIA Director 217-16-0833 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Missical Examinar must be notified at 1 □Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3511 CEDARDALE RD. 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, if a M ponee. Elementary/Secondary (0-12) College (1-4or 5+) -12--0-PORTER MARYLAND CLUB 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WELDON BRADBY ELVIA ALLEN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CANDACE SIMMS (NIECE) 3511 CEDARDALE RD. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial /2 Cremation 3 Removal from State BALTIMORE NATIONAL 2-25-2011 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) ce bicensee JONATHAN D. HIBNER. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Part 7. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cruse (Final disease or condition resulting in death) **Physician** Pheumonia Aspiration /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed Due to (or as a consequence of): physician a the burial-t Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ocardid 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 2 No Division of Vital ı□Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 | Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD P25498 2011 Feb. 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Avenue Balliman, MD, 21229

900

32. Registrar's Signature

Pant.

Nath

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ MAYO BROOKS FEBRUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TATE HOSPICE HOUSE LITHICUM ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 Months Days (Month, Day, 219-32-4482 Director MARYLAND Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director ANNE ARUNDEL GLEN BURNIE 1 X Yes 2 No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6215 ELDRIDGE RD 21060 should be filed within 72 hours after death is and Mental Hygiene.

Is marked other than "natural" action. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3√ Widowed 4 ☐ Divorced Completed Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL COMPANY SALES CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CARRIE BERNICE SYLES LEO WILLIAMS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 POTTERFIELD RD. WINDSOR MILL, MARYLAND 21244 ROBIN BROOKS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial Scemation 3 - Removal from State 4 Donation 5 [Other (Spe CROWNSVILLE VETERANS 2-17-2011 CROWNSVILLE, MARYLAND e of F Service Licensee 22. Name and Address of FacilitWILLIAM REESE & SONS MORTUARY, P.A. ARRY REESE 821 WEST ST. ANNAPOLIS, MARYLAND 21401 3a. Part 1. Enter the dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart fail List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any Inacing to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exam Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform rmed? 2 🔼 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to examiner? 26. Place of Death (Check only one) Be 2 4 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify HOSPICE 1 Tyes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Vilatural 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZD11 Physician/ Ann Bontrager Beverly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
April 30,1939 1 □ M 2 🗓 F Davs Hours Min. Director 218-36-4238 Usual Residence of Decedent "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Dundalk 1 🗌 Yes 2 ី No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21222 USA 8221 Bullneck Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No imore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12 years College (1-4 or 5+) and Mental Hygiene. Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) And Page 1 and 2 shc.

"ent of Health and Ms.
"tem 27 is marked c. ၉ Helen Pendall Angelo Bartecchi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7815 Bertha Road, Pasadena, Maryland Margaret Weber sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of February permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Holly Hill Memorial Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21, 2011 . Signature of Funeral Service Licensee ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or so polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any leading to mind cause. Enter Underlying Cause (Disease or injury Examine Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 completed filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? ivision of Vital 26. Place of Death (Check only one) ဥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after deaf Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nuise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only on 29b. Signatu 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nelson Leighton Bond, Jr. 14 February 12:14 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Good Samaritan Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Days Hours Min. New Jersey **Director** 137-28-0231 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 ☐ Yes 2 🛣 No Maryland Baltimore Owings Mills 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A. 21117 3210 Caves Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. o, by 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. 2 No Specify: White 1 ☐ Yes 2 💢 No Specify: 3 Divorced "natural" Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) filed within tal Hygiene. Medical Equipment Executive Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Minsch Nelson L. Bond, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 Caves Road Owings Mills, Maryland 21117 Wendy Bond / Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hilltop Service Corp 2/16/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Preumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequi Examir ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by stage 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 2 70 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? _1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury s after death. Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of 29c. License number D69540 M-D 2011 アイワ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ad Swit zon Parkville am words Walk 21234 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bu220 06:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hos Balkmore Cir Harbor None 5, Social Security Number If Under 1 Year If Under 24 Hrs. 78 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday Funeral 1**XX**M 2 □ F 09/15/1934^{ear)} 236-48-9689 West Virginia 76 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 10e State within 72 hours after death with the Maryland Director 1 ☐ Yes 2xx No Virginia Monongalia Morgantown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 122 Strawberry Lane 26501 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2XX Married Completed by Baltimore, Maryland 21215-0036 1 Tyes 2 XXNo Specify: and Mental Hygiene. Specify. 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Trucking Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Giuseppe Buzzo Cressie Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Crites Buzzo Wife 122 Strawberry Lane Morgantown, West Virginia 26501 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeters, crematory or other place)

Beverly Hills Cem. & Maus. 02/19/2011 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Morgantown, West Virginia 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Metastatic Physician cancer disease or condition 005 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown is been signed by the should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes |요 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title RESOUD 3001 S. Hanover St., Ballimon, MO 21225

Registrar DHMH 17 Rev 7/2009

State

25604

32. Registrar

Von

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:50 P.M John Neil Burroughs February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days (Month, Day, Year 77 Hours 1 🔀 M 2 🗌 212-32-3449 1933 Balt. Maryland Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Maryland Baltimore Baldwin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 14106 Baldwin Mill Road 21013 of America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2XXMarried þ white 1 Yes 2X No Specify: 3 Widowed 4 Divorced Specify Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry
Baltimore Gas Maryland 21215-(Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) & Electric Company 12 Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Gerard T. Burroughs Carrie Holman permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic once, 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Frances Hope Burroughs/ 14106 Baldwin Mill Rd. Baldwin, Maryland 21013 timore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 17 1 Burial 2 Cremation 3 Removal from State Highview Memorial
Gardens 4 Donation 5 Other (Specify) 2011 Fallston, Maryland Signature of the ery Fervice Lice Peaceful Alternatives Funeral and Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ adenolare disease or condition moruths Medical resulting in death) Due to (or as a consequence of) Examiner Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Day 1 Yes 2 No signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 Natural 5 Pending Investigation __ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a. Certifie 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Number Practioner T, the best of my knowledge death occurred at the time. Sate and place and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print 32. Registrar's Signatur State Registrar DHMH 17 Rev 7/2009

3

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Bay 2011 February 6:49 A^{M} Pamela Hegeman Bialozynski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Hours Min Yrs Maryland 217-62-4707 58 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Bel Air 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 2236 Tollgate Circle 21015U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 K No Specify. If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver School Transportation Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Weakley Johnston Niven Hegeman Susan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2236 Tollgate Circle, Bel Air, MD 21015 Amanda Sanders / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 02/10/2011 Hanover, Maryland Anatomy Gifts Registry 21. Signature of Funeral Service Lice 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ BREAST CANCER disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Penneral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending Investigation Could not be Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year)

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FEBRUARY

PAMELA BIALOZYNSKI

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per TNF G945 11/14/2013 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month
- Ebruan MIRIAM BAROUH Medical liriam 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital of Ltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Min 147054 1919 Director 220-01-0914 Known as N Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Examiner must be notified at Funeral Director 10c. City. Town or Location 10d. Inside City Limits MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 3021 FALLSTAFF ROAD, APT. 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Narried 1 ☐ Yes 2 X No Specify: Specify: "natural" 3XXWidowed 4 ☐ Divorced WHITE other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SERVICE REPRESENTATIVE SOCIAL SECURITY Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumoff: Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH J LIPNICK IDA GREENSPON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROCHELLE SENKER/DAUGHTER 83 WEST LANE, STAMFORD, CT 06905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE CEM 02/15/2011 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ pulmonan disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sa CERTIFICATION NO PROPERTY OF MICHAEL EXAMINES Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or, signed by the attending physician and be detached for use as the burial-transit n that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by fibrillation 24a, Was an s certificate has blirector, page 2 s performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funetal 27. Manner of Death 28a. Date of injury (Month, Day, Year) Febyuan 820 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After 5 Pending work? 1 ☐ Yes 2 🗷 No 1 Natural 2 Accident unknow Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t determined nome e Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of 29c. License number

20c. Location - City or Town, State BALTIMORE, MD SOL LEVINSON & BROS., INC. 21208 Approximate Interval Between Onset and Death IWK 1 wke Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3021 FAUSTAFF RE # 205 Baltimore, MD 21209 NP1 1215765691

6 W PM

MD

1 X Yes 2 No

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trenasi 32. Registrar's Signature

Minera Remero

31. Date filed (Month, Day, Year)

FFR 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2011 11:30 PM HOWARD BLOCK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD 2671 GOLF ISLAND ROAD ELLICOTT CITY 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 XM 2 □ F Days 1477197 1962 **Director** 220-78-4368 48 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2X No HOWARD ELLICOTT CITY 10e, Street and Number 10g. Citizen of What Country? Funeral 21042 2671 GOLF ISLAND ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black White etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SOFTWARE DEVELOPER COMPUTER SOFTWARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 7 is marked o ပ္ LAWRENCE **BLOCK** CHARLOTTE STEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a MARSHA BLOCK/WIFE 2671 GOLF ISLAND ROAD, ELLICOTT CITY, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: If any injury or once, 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM: 02/15/2011 REISTERSTOWN, MD Signatule of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ 11eo cecal Metastatic adenocarcinoma disease or condition resulting in death) Medical Examiner 32 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events -trans Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify, 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

P.O. Box 68760 Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director,

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D69970 2011 Medical Doctor. address of person who completed cause of death (Item 23a) (Type, Print) 401 NORTH BROAdWAY phanie allard , Room 1363 Baltimore, MD 21231

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29d per doc 9912 2-23-11 vt.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ FEBRUARY 11:25 A M 2011 DAVID BARABAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5833 PARK HEIGHTS AVENUE, #305A N/A BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last hirthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral 1 □XM 2 □ F Days Hours 01775971913 095-18-2639 98 NY Director Usual Residence of Decedent or 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Tyr Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 5833 PARK HEIGHTS AVENUE, #305A 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ♥ Widowed 4 Divorced WHITE Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
amply or other traumatic event, the Medical I
once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURER GARMENTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BARABAN SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 MOONSPUN COURT, BALTIMORE, MD JAY BARABAN/SON 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ARLINGTON CHIZUK AMUNO CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/14/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. (S) 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ They Congestore disease or condition Medical resulting in death) **Examiner** weeks 6 sellson Sequentially list conditions Examine Due to for as a consequence of. if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Yes 2 No After this certificate has been signed by the funeral director, page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Deneros 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 🗙 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Natural injury 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-13-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glabina 31. Date filed (Month, Day, Year) State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State Registrar		_	Cer	tificate of	Death			Reg. No	.201	143
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Medi		Thelma B					Ebruar	0	13 7011	1:40		
Exami	ner	4a. Facility Name (if not institution				4b. City, Town, c				40	County of Dea	
		SEASONS HOSPI 5. Social Security Number				RANDA If Under 1 Year			0 Data of Dist	1	BALTIM	
Funeral Director		050-18-7350 Usual Residence of Decedent	1 M 2 X F	Age (In yrs. Ias	Yrs.	Months Days			8. Date of Birl 05/21/	1923	9. Bit	rthplace (State or Fountry) NY
perfull Def. Mal yialing Z IZ 13-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. Coun	•	10c. City,	, Town or Loc	cation			_			10d. Inside City
	ie.	t	ALTIMORE	J OW	VINGS 1							1 🗆 Yes 2
	Funeral Director	10e. Street and Number 3 REGALIA CO	URT, APT. B			10f. Zip Code	117			10g. Ci	itizen of What C	ountry?
death item ner n		11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	. 13. V	Vas Decedent of H Yes, specify Cub	Hispanic O an. Mexica	origin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ame Black, Whit	
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Mer Mer narke	-	BENNY		KATZ			M.A	ARSHA				KATZ
d 2 shoualth and rate rate		19a. Informant's Name/Relation				g Address (Street EGALIA C				-		
1 an of He riten		20a. Method of Disposition	- 1787-			sition (Name of natory or other pla	cel	Da	te	20c. L	ocation - City o	r Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Joyce Brubaker 02 2011 8:16 A 80 /Medical 4c. County of Death Harford 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace Harford Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 289-28-2550 77 Yrs Director 9/06/1933 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or iteme 23a or 28a-f ehow traumatic event, it a Medical Examination to rotified at Yes 2 No Havre de Grace Maryland Harford Directo the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 1034 Chesapeake Dr., Apt. 8E Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Author Performing Arts 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fit and Mental Fit is marked of Walter McConnell Fanny Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Grace, 1034 Chesapeake Dr, Apt 8E, Havre de MD 21078 19a. Informant's Name/Relationship (Type, Print) James Brubaker / Husband of Health item 27 i 20c. Location - City or Town, State West Chester, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
importent: If ite
eny injury or ott 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 02/10/2011 4 Donation 21. Signatur Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 and 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician CARDIOGENIC SHOCK /Medical Due to (or as a consequence of): Examiner METABOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ► No page 2 s 24a. Was an autopsy performed? director Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by filled in by 4 \(\text{Homicide} \) ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-8-11

DHMH 17 Rev 1/2001

State Registrar

BRUBAKER JOY

32. Registrar's Gignature

Harford Memorial Hospital Bel Air, MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Puthawala

31. Date filed (Wonth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Imend #1 Per PHY G912 2/18/2011 JH

State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Foster Lizzie Physician/ Month & Carter Lizzie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore NΑ Good Samaritan Hospital ecurity Number 6. Sex 1 M 2 K F 8. Date of Birth
(Month, Day, Year)
09-01-46 Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours Min. 225-62-2676 **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1X XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1617 East 30th Street 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Black, White, etc. African Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: If Yes, Give ^{Specify:}American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working id Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Facities 12th Grade Assistant Living Manager NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be 1 Department of Health and Menta Important; If item 27 is marked Cephus Bishop Constance Everette 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Melton-1617 East 30th Street Baltimore, MD 21218 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 02-23-11 Metro Crematory Catonsville, MD injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signatule of Funeral Servide Licensee 9200 Liberty Road Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ c ordi d 0 my disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) the attending physician and thed for use as the burial-transit Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 51 1 Yes 2 No 3 Probably 4 Unknown Completed Varalm 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natura. 2 Accident 5 Pending work 1 Yes 2 No Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) phy sicion 045650H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560/Loch Paven Blvd State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ COPFLAND 8: 00 AM MABLE 02 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE CITY BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Hours Min. Month 1 Day, Year 9 3 2 N.C. **Director** 273-30-5204 ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1732 Hartsdale Road 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Be Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 3 🗌 Widowed 4 🗀 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Bayview Hospital 12th grade Patient!s Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vandervilt Copeland Savannah West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur C. Grigsby-Husband 1732 Hartsdale Road Baltimore, MD 21239 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Garrison Forest 2-22-2011 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Examiner CONGESTIVE HEART Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit HYPERTENSION . that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 2 been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 M Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? RIGHT KNEE INFECTION 24a. Was an page 1 Yes 2 No Yes 2 X No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🔀 No ျ 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier CHAUDHARI, 29c, License number 29d. Date signed (Month, Day, Year) RESIDENT PHYSICIAN maudhari RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR-SAMEER CHAUDHARI, 5601, LOCH RAVEN BLVD, BALTIMORE, MD-21239

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year) -- - -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lason Cheslik	State of Maryland / Department of 1- For Stata Certificate of Registrar	f Death	2011 0437 <i>1</i> Reg. No.
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Jason Matthew Cheslik	2. Date of De Month February	path 3. Time of Death 0239 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral Director	Franklin Square Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214 17 7852 1XM 2 F 29 Yrs	Months Davis Hours Min	Baltimore County Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Marryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion	10d. Inside City Limits
*	Maryland Baltimore City Baltimore Ci		1 X Yes 2 No
th the Maryland 23s or 28s-f sho notified at once,	10e. Street and Number 4425 Raspe Avenue	10f. Zip Code 21206	10g. Citizen of What Country? USA
er death wi , or items r must be Funer		is Decedent of Hispanic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 V No specify:	14. Race - American Indian, Black, White, etc. Specify: White
nours aft	15. Decedent's Education (Specify only highest grade completed) 16a. Decedenduring medium grade during medium grade completed)	nt's Usual Occupation (Give kind of work done lost of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 led within 72 hours at tygene. other than "natural the Medical Examin Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	Supervisor	R & L Carriers
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	, Maiden Surname)
2121 tould be fi d Mental I is marked tite event, To Be	Lawrence Matthew Cheslik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Patricia A Stan g Address (Street and Number or Rural Route Nu	
MD id 2 shoulth and m 27 is soumation	· · · · · · · · · · · · · · · · · · ·	Raspe Avenue Baltimore, Mary	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatit event, the Med To Be Com	1 N Burial 2 Cremation 3 Removal from State crematory or oth	sition (Name of cemetery, Date her place) Conctery February 17 2011	20c. Location - City or Town, State Baltimore, Maryland
altim mit. Pa partmen portant ury or o	4 Donation 5 Other Specify.	Name and Address of Facility Lassahn Funeral Home Inc	Datembre, rary tand
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the		Maryland 21236 rrest, shock, or heart Approximate Interval
Physician Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	te mode of dying, such as cardiac of respiratory ar	Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):		
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ted Insit Examine	(Disease or injury triat initiated events resulting in death) Last Due to (or as a consequence of):		
50, te be executed sysician and burial - transit	d:d:		
760, cate be physicis the buris	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy npletely filled in by the funeral director, page 2 should be detached for use as the b ilical Certification: To Be Completed by Physician/Me	past 12 months? 4 Pregnant at time of death 5 Ott	tal death 3Ectopic pregnancy her (Specify)	Month Day Year
D.O. BO) that the death ned by the and detached for by Physi	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
res that the signed by be detach		· · · ·	es 2 No 3 Probably 4 Unknown
Records, P.: The law requires the ficate has been signed. page 2 should be d. Completed b.		24a. Was	ppsy prior to completion of cause of
tal Recian: The la certificate hector, page 2		1 Yes	
of Vital Recing Physician: The After this certificate funeral director, page on: To Be Com	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	26. Place of Death (Check only one) 3 DOA Other Nursing Home 5	Residence 6 Other:
Division of Vital Records, talor Attending Physician: The law requirers after death. **I Director: After this certificate has been sited in by the funeral director, page 2 should bertification: To Be Completed entification: To Be Completed	27. Manner of Death 1 Natural 5 Pending FOUND: 28a. Date of Injury 28b. Time of Information (Month, Day, Year) FOUND:		how injury occurred struck by auto
Division o spital or Attending rours after death. neral Director: After filled in by the fune Gertification:	2 Accident Investigation Feb 13, 2011 0204 hrs 28e. Place of Injury - At home, farm, street	et, factory, office building, etc. 28f. Location	(Street and Number or Rural Route Number, City
Division of A popular of A pours after meral Direct Direct Office of A printed in E	4 Homicide determined (Specify) Local Street	or Town, Hazelwood A	State) Ave and Emelia Ave, Rosedale, MD
To the Hospital within 24 hours To the Runeral completely filler	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur one) Wedical Examinar: On the basis of examination and/or investigat		* *
To wit	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	20 Name and address of parson who completed source of death (from 325)	O.C.M.E.	February 13, 2011
	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900	W. Baltimore Street, Baltimore, MD 2	1223
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
DHMH 17 Rev 1/2001	OGME ORIGINAL	L	
OCME 2006	ODIVIC		

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AMEND ITEM# I per PHYS, G912, 2/16/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Lisa Ann Cunningham Year **Physician** Month 1221 PM tebruare /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 3/13/1962 5. Social Security Number Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F 48 226-11-5508 Director Washington,D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Mary1and Howard Ellicott City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5 Examiner must be 8073 Brightwood Court Funeral 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: White \$ 3 ☐ Widowed 4 ☐ XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Vice President Maryland Division of Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. 12 Hohman and Barnard. Inc other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental I Charles Edward Anderson Elizabeth Roene Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Hicks/ Fiance 8073 Brightwood Court, Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Tremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2/7/2010 Glen Burnie, Maryalnd 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 7250 Washington Blvd.,Elkridge,Maryland 21075 23a. Part 1. Exercise disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition Dhoc resulting in death)) /Medical Due to (or as a consequence of) Examiner tecdosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events and use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: $_{4} \square$ Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury After this funeral (27. Manner of Death 1 Natural 28b. Time of . Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending Injury death. I Director A Accident investigation 1 Yes 2 □ No 3 Suicide Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is an examination and on the cause of the Funeral 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 one) within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) February 2,201 Kes- 000 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Ben 19 m. 600 North Wolfe St, Baltimore, MD, 21287 a de 31. Date filed (Month; Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Counts Physician/ Month Day Vincent 4:15 A M February 7011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo 8-1-1958 Funeral 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) 214-64-8416 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No MD Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6433 Woodgreen Circle 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Completed by 1X Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: African-American 3 🗆 Widowed 4 🗀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Entrepreneur</u> Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isadore Counts Sr. Ethel Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Counts/Mother 6433 Woodgreen Circle, Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2-14-2011 Baltimore, MD 21. Sign, ure of Funeral Service Licens 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on easil line.

Immediate Cause (Final End - 574 Re Liver Disease Interval Between Onset and Death Physician/ End-Stage Liver Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Twithin 24 hours after death.

To the Funeral Director: After this certifies Division of Vital To Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 9 Other (Specify) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ms Rejapalise M.D 00057465 2/11/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N S. Rajapakse, M.D. , Baltimore, MD-2)209 5-203 5milli AV 2835 31. Date filed (Month, Day, Year) FEB 1 6 201 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 26 pr verb., g912,02,16,2011dhb Certificate of Death Reg. No. For State Registrar dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:40PM Medical 4c. County of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Number 013 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Jast birthday **Funeral** 1 M 2 D F Months Hours Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director ALIMORE 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itemany injury or other trainment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 Specify: BLAC If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1100 Be 17. Father's Name (First, Middle, Last) 18. Mother,'s Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gardgen Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) emetery, crematory or other place, 21. Signature of Funeral Lervice Li. In ee 23a. Part 1 Epterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Diabetes mellitus Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Fibrillation, hypertension 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performe 2 **X**No 1 Yes Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 💆 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident 24 hours after deatl Funeral Director: Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contiguing Nurse Fractioner: To the best of my kine accepted at the cause and due to the cause (s) and manner stated. (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 3, 2011 D51807 my) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 419 W. Fedwood St. Steb20, Baltimore, MD 21201 Yim, mo 31. Date filed (Month, Day, Year) 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Registrar

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32. Registrar's Şignature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Bultimore, in 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Z 2011 4:15 am rea arring . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Louisiana Months Davs Hours Min Director 536-26-0761 86 07-05-1924 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits Director 1X Yes 2 ☐ No Md P.G. Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4630 Pendall Drive 20744 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Ś 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 XWidowed 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Day Care Provider Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Uriah Causey, Sr. Lucinda Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7711 Lanham Lane, Ft. Washington, Maryland Regina C. Ebuwei - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 ☐ Cremation 3 ☐ Removal from State Md Veterans Cemetery | 2-17-2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature o Funeral Service Lice 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Maryland 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Stemic Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine hemo neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy☐ Other (specify) ___ 3 in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 1 No Other: မ 1 DInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of Certificate: 24 hours after death. Funeral Director: After 28d. Describe how injury occurred Natural injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗓 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe no completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 16 2011 32. Registra 's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12, Month February Nancy Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Talbot 23014 Claiborne Landing Road Claiborne Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Days Min (Month, Day, Year) 01/10/1936 **Director** Yrs 218-32-7666 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified MD Talbot Claiborne 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23014 Claiborne Landing Road U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 🛚 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary Teacher Education 1 and 2 should be filed with f Health and Mental Hygier item 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Herbert Hilda Krill R. Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) K. Lorraine Renshaw / Daughter 29170 Rabbit Hill Road, Easton, MD 21624 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 02/14/2011 Hanover, Maryland Signature of Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 Tyes ည 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28d. Describe how injury occurred iniury 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 🗌 No Accident Investigation ☐ Acciden
☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

ORIGINAL

Registrar's Signature

2011

7:40 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 ☐ No

Maryland

White

Day

1 ☐ Yes 2 ☐ No

29d, Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FORTURE 2104 Elizabeth Louise Davis Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death 4c. County of Death **Examiner** maryland Greneral 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs Days Hours Min. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K (Month, Day Year) 946 Country) 132-38-1850 64 N.Y. Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 Yes 2 No MD na Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11 W. 20th Street Apt 11L 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 1.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other transmany injury or other transmatic event. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GED Save A Lot Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Hilliard Phyllis Wharton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 McElderry Street Balto, MD 21205 Tina Davis-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2/21/2011 Baltimore, Greenmount 4 Donation 5 Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility L 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of, the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day page 2 should be detached Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy death? 2 🗌 No Director: After this certificate 2 N 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours after of Funeral Direct filled in by determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number ne and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 34 OM Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and num DAILIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Social Security Number Days Months 1 ☑ M 2 ☐ F 49 454-01-3977 21,1961 MĎ Dec Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore MD N/A1X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA 2117 Dukeland Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**No Specify: Black 1 ☐ Yes 2 🕱 No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Employed 12th N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Edward Dixon Imagene Fairchild Carey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Womble/Niece 307 E. Lafayette Balto., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey 2/16/2011 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Charisse N. Woods F/S 21. Signature of Funeral Service Licenses 2700 Edmondson Ave. Balto., MD 21223 23a. Parts Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIBALORY ARREST Due to (or as a consequence of): PARPHEWNONIC Effasion/EmpyeMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2□Mo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be

Physician /Medical **Examiner** requires that the death certificate be executed burial-trar Box 68760. physician the as attending for use P.0. the ģ

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

a or

'natural", or items 23a dical Examiner must b

traumatic event, the Medical

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Hygiene.

12 should be filed w h and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic ew

72 hours after

Maryland 21215-0036

altimore,

Director

Funeral

2

Completed

Be

2

Examiner signed to page 2 s certificate | funeral director this Hospital or Attending P 4 hours after death. Funeral Director: After t After t the

Records,

Division or Vital

Physician:

within 24 hours a Hospital

filled in by

Physician/Medical þ Completed Be ပ္ Certification:

3☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

30. Name and address of person who co

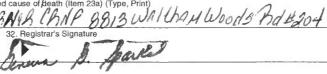
State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day,

HOLLAND



leted cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2:35 AM 201 Curtis Ellsworth Dexter 4b. City, Town, or Location, of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death tanes 105 timore If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1**X** M 2 □ F 82 Feb 1929 Maryland 218-22-8609 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 **USA** 48 Dunvegan Road 12. Was Decedent Ever in U.S. Armed Forces? 1√DYes 2 ☐ No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stamp & Coin Dealer Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellsworth P. Dexter May V. Dranbauer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Meng / NEPHEW 5016 Paducah Road, College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Metro Crematory Inc. 02-15-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society Of Maryland, INC ture of Funeral Service Licensee Patrik Fleming 299 Frederick Road, Baltimore, MD 21228 Part 1. Enter the disease, or com shock, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Fw OAYS Immediate Cause (Final NEUM-NIA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) TYes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No 1 □ Yes 2 **2** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

Physician Medical Examiner Examine

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be မ

Funeral

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

The law requires that the death certificate be execute

Records,

Vital

Division of

Physician/Medical

attending physician and Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

Completed by Be Certification: To

Medical

within 24 hours a 9+1

State

MATEEN

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

6 ☐ Could not be

determined

MA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 120062634

1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) FEB 14, 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

COLUMBIA MA 21.44

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AWAN HICKORY RIDGE 10796

31. Date filed (Month, Day, Year) 16

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

			For State	State of Ma		d / Depa	artment of	Healt	h and N	-		_	C.	14387
			Registrar 1. Decedent's Name (First, Middle, La	pet)		Cer	tificate of	Deati		0.0.4.40	Reg. No	<u>. U I I</u>		7 1 0 0 .
	Physicia	ın/	Ellen G. Doole	•						2. Date of De Month 0 2	Da O S	y 20°	ar 1	3. Time of Death 4:00 PM
-	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Town	or Location	on of Death	<u> U Z</u>		County of D		
-	LAdillii		Harford Memor		tal		Havre			ce	1	rfor		
	Funeral		5. Social Security Number 6.	Sex 7. Age		ast birthday)	If Under 1 Year Months Day	ar If Und	der 24 Hrs.	8. Date of Bi	rth	9.	Birthpl	ace (State or Foreign
	Director		408-58-6998	1 □ M 2 🗶 F	72	Yrs.	WOTHIS Day	5 Hour	S IVIII.	June June	7, 19	38 TI	Birthpl Countr	y/
	oow te	_	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation						10	d. Inside City Limits
	arylar a-f sh fied a	cto	Maryland Harf	ard		erdeer							"	1 ☐ Yes 2 ☐ No
	or 28 e noti	ğ	10e. Street and Number		AD	<u> </u>	10f. Zip Code				10g. Cir	izen of What	Count	
	with t	Completed by Funeral Director	3604 Churchvi	lle Rd.			2100	1			USA			
	leath items er m	ᇤ	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.S	S. 13. V	Vas Decedent of Yes, specify Cu	f Hispanic	Origin? (Sp	ecify Yes or No-		14. Race - A		
36	", or	ğ	1 Never Married 2 Married	1 ☐ Yes 2 ☒️I If Yes, Give	No		Yes 2 🕅			Thousand Story		Black, W Specify: W		
8	ours a	eted	3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates.										
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bu	filed valued by a doth	Be	17. Father's Name (First, Middle, Last,							ne (First, Middle		Surname)		
yla	ld be Ment arke	잍	Virgil Fletch					Lu	cile	Mangr	um ———			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental lygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Wanda Schwab	Type, Print) / Daughte	r	19b. Mailir	g Address (Stree Walthe	et and Nur.	mber or Run	al Route Numbe	er, City or	Town, State,	Zip Co	0 6
e,	and 2 Health em 2; ther t		20a. Method of Disposition	Daugnee			sition (Name of	or N	· ·					
Ö	nt of Int of It. If it		1 Burial 2 Cremation 3	Removal from State	20b. F	emetery, cren	natory or other p	lace)	2/11	Date 1 / 2 0 1 1	Wes	st Channeyl	est	er,
Baltimore,	nit. Pa artme ortan injury	1	4 ☐ Donation 5 ☐ Other (Spec		10.7				<u>: </u>					
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	Physician/	- 6	Immediate Cause (Final disease or condition		חומי	GENIC	CHI	OCK						Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequ	uence of):	2 110							
	Examine	<u>.</u>	Sequentially list conditions, b. MYOCARDIAL ISCHEMIA						4				1	
	od sit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury									7.4		
	and and Il-tran	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequ	uence of):							+	
0	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical		• d										
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. 89	ath certificate battending physical for use as the batter that the batter than	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			l Ectopic pregna	ancv.				23d. Date of	deliver	у
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P.O.	at the	Phy	9 Unknown Part II. Other significant conditions		t not rec	ulting in the u	ndorkina cause	given in D	art I	00- Pill			. 4 . 41	cause of death?
	requires that the de been signed by the should be detached	Completed by	Tarvii. Other significant conditions	contributing to death be	11101103	alling in the u	nderlying cause	givoniiii	art i.					ably 4 Unknown
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Vita	/sicia s cert direct	To Be	examiner? 1 \sum Yes 2 \sum No	Hospital:	nt 2 🗆	ER/Outpatien		ther		ome 5 🗆 Resi	donco 6	Othor (St	accifu)	
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Division of Vital Records,	or Att fter d irecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injul						28f. Location (Rural F	Route Number,
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Exar	ysician: To the best of r niner: On the basis of ex rse Practioner: To the b	amination	n and/or invest	igation, in my opi	inion, death	occurred a	t the time, date	and place	and due to t	he caus	e(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	To the tollow in the tree to	CST OF ITIS	Knowledge, c		nse numbe		se, and due to t		e signed (Mo		
			1	me			DO	0691	18		2.	10-1	١	
)			30. Name and address of person who	10 10	ath (Item	23a) (Type, P					1	Y	11	2.70
	المراجع الم		Khallo Futha (31. Date filed (Month, Day, Year)	UALA, MD	50	1001		MVE	- MA	urea	60	RACE,	ML	4010
	Stat Registra		FEB 1 6 20	32. Registra	s signat	ure far	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Richard Lee Everd 9:26 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Parkton 17800 Foreston Road 8. Date of Birth Month, Day, Year) May 26, 1945 Social Security Number 7. Age (In yrs. last birthday) 65 yrs If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Country) Maryland Min. Months 213-46-0939 Hours Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Baltimore Parkton Maryland 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States of America 21120 17800 Foreston Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) State Highway th and Mental Hygiene.
7 is marked othersaum. other than Elementary/Seconday (0-12) College (1-4 or 5+) S.O.C. Supervisor Administration 12 Be and ; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 0 Dorothy May Wilt Robert Bartholomew Everd Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17800 Foreston Road, Parkton, Maryland 21120 Linda Joyce Evend - Scouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Forest Rioge Baptist Church Caretery February 16 Upperco, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Fyans Funeral Chapel and Cremation Services - Monkton
16924 York Road, Monkton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Pancienter Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Year Day ed by the a Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) this eral Director: After thi filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year) D0026575 02-11-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21030 STF 200 YORK RD COCKEYSVILLE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 16 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ II, 2011 FEBRUARY 5:50 AM MARVIN **EDELMAN** Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7111 PARK HEIGHTS AVENUE, #603 N/A BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours 0671571913 **Director** 489-01-0662 97 MO Usual Residence of Decedent "natural", or items 23a or 28a-f show edicaf Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1

Yes 2 □ No N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral th and Mental Hygiene. ?7 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must I 7111 PARK HEIGHTS AVENUE, #603 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2X Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. 3 Divorced 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) EDISON BROS. Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien 7 is marked other th VICE PRESIDENT SHOE COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **EDELMAN** DORA KAISER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a ROBERT EDELMAN/SON 6712 WESTBROOK ROAD, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 듄 permit. Page 1 Department of Important: If it any Injury or or 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHEVRA AHAVAS CHESED 02/11/2011 RANDALLSTOWN, MD 21. Sign tun of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. echae 8900 REISTERSTOWN ROAD, PIKESVILLE. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) y hy properties Medical Due to (s a consequence of) **Examiner** mormony moun Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1233974

Registrar

BATA MI LIZES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coldson

31. Date filed (Month, Day, Year)

FEB 1 6 2011

2835

SMIR

32. Registrar's Signature

Charles Ernest Griff		of Maryland / Dep		Health and		giene	201	1 94390
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Ce	runcate or	Dealir		2. Date of Death	J. No.	3. Time of Death
Medical Examiner	CHALLES ELLESC GLI					Month February 1		1846 hrs
	4a. Facility Name (if not institution, give Johns Hopkins Hospital	street and number)	1	4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of D	eath
Funeral	Social Security Number	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9	Birthplace (State or
Director	212-88-1850 1XI		Yrs	Months Days	Hours Min.	March 1		oreign Country)Maryland
	Usual Residence of Decedent					1-22-011	.,	
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uyland ta-f sh tt once	Maryland N/A 10e. Street and Number	Ba.	ltimore	10f. Zip Code		100	g. Citizen of What	
the Maryland a or 28a-f sh tiffied at once	205 N.Dallas Ct.			21 231		14	USA	
h with h with be no be no	11. Marital Status	12. Was Decedent Ever in L Armed Forces?		s Decedent of Hispa es, specify Cuban, N				merican Indian, Black,
er death with t	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No		_		riodii, oto.)	Specify: Bl	
urs after	15. Decedent's Education (Specify only	or Dates:	16a. Deceden	t's Usual Occupation	n (Give kind of w		16b. Kind of Busine	
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5-0036 ed within 72 hours tygiene. the Medical Exan Completed	6th grade 17. Father's Name (First, Middle, Last)		Labo		.Mother's Name	/Eiret Middle Ma	Construc	tion
215- be filed ntal Hyg rked off	Randolph Jones				Gloria G		alderi Surriame)	
212 tould b d Meni is marl tic eve	19a. Informant's Name/Relationship (Typ	oe, Print)		Address (Street a	and Number or R	ural Route Numb		tate, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Chishala K. Griff 20a. Method of Disposition			I. Dallas			1D 21231 20c. Location - Cit	y or Town State
Ore, ges la tof He tof He tof the tof	1 Burial 2 Cremation 3	Removal from State	crematory or oth	er place)				
Itim ii. Pa irtmeni ortant	4 Donation 5 Other Specify: 21. Signature of uneral Service Line		inity Ce	metery ame and Address o	2-18 f Facility	8–2011 n–Har	Dundalk,	MD ral Home
Ba perm Depr Imp	Elion Jan	NE		40 Reiste				
Physician //Medical	23a. Par I. Enter the fiseas, or complication. List only one cause on each	n line.				respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
žxaminer		eroin and ald		toxicatio	on			Death
	Sequentially list conditions, b	de to (or as a consequence	O1).					
iner	if any, leading to immediate Di cause. Enter Underlying Cause	ue to (or as a consequence	of):					
ted nnsit Examine r		ue to (or as a consequence	of):					
executed ian and ial - transit	d. X UNPENDED	AMENDED 27 20-						
58760, artificate be eling physicia as the buria	IF FEMALE:	23a, 27, 28a- 23c. If yes, outcome of pre-		E g913 3/	/3/11 TT		23d. Date of del	very
x 687 h certific tending p use as th	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of d	2 Fe	tal death 3	Ectopic pregnar	псу	Month	Day Year
). Box 68760, the death certificate be by the attending physic cled for use as the bur Physician/Med	1 Yes 2 No 9 Unknown	9 Unknown	5 Oti	ner (Specify)				
P.O. E s that the d	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.			e to the cause of death?
S, P					·	1 Yes		Probably 4 Unknown a autopsy findings available
Records, The law requires ficate has been sig page 2 should be Completed	·					autopsy perform	y prior	to completion of cause of
ital Recitan: The scerificate rector, page	25. Was case referred to medical			26 Place o	f Death (Check o	1 Yes 2	No 1 ✓	Yes 2 No
Vital ysicians his certi director		spital: 1 Inpatient 2 ✓	ER/Outpatient		thor 🗔		esidence 6 0	other:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Ir			28d. Describe hounk	w injury occurred	
Sion Attend death. cetor: by the f	2 Accident Investigation	Fd 2/11/11 28e. Place of Injury - At I	fd 1805	пгь	s 2 140		root and Number o	r Rural Route Number, City
Division o ospital or Attending hours after corral Direction: After y filled in by the fune Certification:	3 Suicide 6 Could not be determined	(Specify) reside		et, ractory, office buil		or Town, Sta Baltimo:	ate) 205 N d	lallas Ct
Division of Vital Records, P.O. Box 68760, ro the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. In the Thorna Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burined deciral Certification: To Be Completed by Physician/Med	29a. Certifier 1 Certifying Physician	n: To the best of my knowled	dge, death occur	red at the time, date	and place, and	due to the cause	(s) and manner as	stated.
To the Ho within 24 P To the Fu completely	8	On the basis of examination and manner stated.	and/or investigat					
	29b. Signature and title of certifier		(1)	29c. License r			29d. Date signed February 12,	
de	30. Name and address of person who co	mpleted cause of death (Iter	m 23a)	11				
sent		ssistant Medical Exa	miner 900	W. Baltimore S	treet, Baltim	ore, MD 212	23	
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signar	1 bar	es .	- · 			
DHMH 17 Rev 1/2001	I LU - V CVI	· · · · · · · · · · · · · · · · · · ·	ORICINAL		OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Betty Jean Gurtler 3:00 A. M February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number 6. Sex If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛱 F 61 (Month, Pay, Year) 09/05/1949 Martyland 214 52 8349 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Glen Burnie Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 619 New Jersey Avenue, N.E. 21060 U.S.A. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Ş 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Owner Commercial Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ Glen Thomas Henderson Minnie Beatrice Cannon permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 New Jersey Ave. N.E. Glen Burnie, Maryland 2106 Lloyd Gurtler / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Glen Burnie, Maryland 02/16/2011 4 Donation 5 Other (Specify) Glen Haven Mem. Park 21. Signature of Juneral Service Lic 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final en Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) the a Unknown 9 🗌 Unknown certificate has been signed by irector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobageo use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death?
1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ER/Outpatient 3 DOA

To the Hospital or Attending Physician: The law requires that the death certificate be executed this After t

Certificate: To

Medical

within 24 hours are:
To the Funeral Director: Aft

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 t 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 02/12/2011

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 16 Dark

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

8021

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KITCHIR INY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 4c,9 per dr/fh, g912,02716/2011dh Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Day enise Medical 4a. Facility Name (if not institution, **Examiner** City, Town, or Location of Death 4c. County If Under 24 Hrs. 8. Date of Birth last birthday) **Funeral** Months Hours Days **Director** "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No BALTIMORE 10e. Street and Number APT. 6C 10g. Citizen of What Country? Funeral RANKIIN 21201 U.S.A STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates BLACK 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE MEDIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ EANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/344 PAYTON MARV TAVEN DR. 504 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other to once. WINDSOR MILLS, MARVIAND or other 20a. Method of Disposition
1. ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 08/2011 BALTIMORE, MARVIAND KING MEM. PK, CEME. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The DERRICK C. JONES FIH, P. A.
41011 DADIN HOTE AND ROLL 21215 nature of Funeral Service icensee 4611 PARK HGTS. AVE. BALTIMORE. 23a. Part 1. Enter the disease, or complication caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, A proximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sign Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or imjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year 9 Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: မ 1
Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural

2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fenouge Ci James Madison Graham, Sr. 11:30 AM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death ANNE Burnie HRuncle CENTER Glen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 27, Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F Months Days Hours 219-32-2204 74 Director 1936 Baltimore MD Oct Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 308 Mountain Ridge Court Apt.E United States 21061 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 2X No 1 Never Married 2 Married à 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other th Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Woodrow Wilson Graham Edna B. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglass Graham/ Son 9 Montauk Court, Baltimore, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If its
any injury or of February Dulaney Valley 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 17, 2011 ál Gardens 22. Name and Address of Facility Evans Funeral 8800 Harford F Signature of Funeral Service Licensee Chapel & Cremation Services Rd Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Physician/ ase or condition Medical sulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. (Pleases or lighty Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ icate has been sig , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate funeral director, page 2 ANO 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) Natural 5 Pending n 24 hours after death.

e Funeral Director: A pleted filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Prestioner To the best of my knowledge, death occurred at the time, date and place, and due to the c auso(s) and manner as state 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 12,2011 Doors 703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tison Berhane, M.D., 301 Hospital Drive, Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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ORIGINAL

11-01227 Debra Susan Gill

11-01227 Debra Susan Gi	li	Please Type or Print in Black Inde	elible Ink. Ensure All Cop ment of Health and Mental I	ies Are Leg	ible.	04394	
		1- For State Certif	icate of Death		g. No.		
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death	
Medical Exami	ner	Debra Suzanne Gill		February 1	3, 2011	0847 hrs	
)		Facility Name (if not institution, give street and number) Stade Avenue	4b. City, Town, or Location of Dea Pikesville		4c. County of Death Baltimore County		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last) 1 M 2 X F 55	birthday) If Under 1 Year If Under 24H Months Days Hours M Yrs.		(MM/DD/YYYY) 9. Bird , 1955 Foreig Cor	inplace (State or In Unit Maryland	
5		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location			10d. Inside City Limits	
D	ŗ	MD Baltimore	Pikesville			1 Yes 2 XNo	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 223 Slade Avenue	10f. Zip Code 21 208	10	g. Citizen of What Cour USA	itry?	
with t	<u>ra</u>	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (can Indian, Black,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced or Paties:	If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No specify:	to Rican, etc.)	White, etc. Specify: Whit	е	
nours a			a, Decedent's Usual Occupation (Give kind o during most of working life, DO NOT use re		16b. Kind of Business/li	ndustry	
215-0036 be filed within 72 Intal Hygiene. rked other than "-	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Paralegel	Í	Attorneys	Office	
15-C filled v I Hygi	-	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mi	•		
212 ould be Menta marke	To Be	Walter Marshall Gill 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of		_	, Zip Code)	
MD 12 sho th and th and to 27 is umati		Nellie L.Gill-mother	4300 Cardwell Avenue				
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		1 - Burial 2 Cremation 3 Removal from State crem	e of Disposition (Name of cemetery, natory or other place) Hill Memorial Fe		20c. Location - City or Middle Rive	Town, State er, Maryland	
altin mit. P. partme portan		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	22 Name and Address of Facility	1	2		
	q	indise h ME Forde	Evans Funeral Cha 8800 Harford Road				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.		or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death) a Gabapentin int Due to (or as a consequence of):	oxicaiton			Death	
		Sequentially list conditions, b					
	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last					
ecuted and transit	ш	events resulting in death) Last Due to (or as a consequence of): d.					
8 5 -	an/Medical	☐ AMENDED 23a,27,28a-f	per ME g913 3/3/11	TT			
Box 68760, e death certificate be ex the attending physician ed for use as the burial.	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregr		23d. Date of delivery Month D	day Year	
Box te death the atte	Physicia	1 Yes 2 No 9 V Unknown 9 Unknown	5 Other (Specify)				
F. P.O. ires that the signed by t	by P	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to t	the cause of death? ably 4 Unknown	
ords, F w requires is been sign should be				. 24a. Was ar	2-11-2-11-1	topsy findings available	
cords law requi	Completed			autopsy	prior to coned? death?	ompletion of cause of	
tal Recions: The lactificate lactor, page		25. Was case referred to medical	26.Place of Death (Checl	1 Yes 2	No 1 Yes	s 2 No	
Vital hysician this cert	o Be	examiner?			esidence 6 🗸 Other:	Scene	
n of ding Ph	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28l	b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred		
Sion ttendi death. ctor:	atio	2 Accident Investigation	1 8:35 am 1 Yes 2 X No		ingested d		
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the sure death. Frai Director: After this certificate has been signed by tilled in by the funeral director, page 2 should be detach	Certification:	Suicide Could not be	farm, street, factory, office building, etc. residence	28f. Location (Str or Town, Sta Pikesvil	reet and Number or Rur ste) 223 Slade 1e, MD	al Route Number, City Ave	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.					
¥ 2 4 8	₹	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)	
		in w. Vs	O.C.M.E.		February 14, 201	1	
		 Name and address of person who completed cause of death (Item 23se Ling Li, MD Assistant Medical Examiner 900 W. 	•	1223			
Sta	-	31. Date filed (Month), Pay Year) 22. Registrar's Signature	hod.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Februar Physician/ 1900 Donald Jay Hunt III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges' Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Massachusetts Director 023-56-2551 44 03/12/1966 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State **Funeral Director** 1 Yes 2 □ No Upper Marlboro MD PG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 USA 16411 Village Drive West 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Founder, CEO Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Leona J. Fisher Donald Jay Hunt, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16411 Village Drive West; Upper Marlboro, MD 20772 Rachelle Hunt - Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/18/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) <u>Chesapeake Crematory</u> 21. Sign and of Funeral Service Ligensee 22. Name and Address of Facility Freeman Funeral Services 4594 Reech Road: Temple Hills. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vehicle Accident Noton Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2-No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28d. Describe how injury occurred distilled 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 1 Natural (Month, Day, Year) CAN STRUCK True 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Bural Route Number, City or Town, State) South Branch Comments 28e. Place of lutury - At home, farm, street, factory, office building, etc. (Specify) STreet Wate Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print S 300

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Registrar

State Registrar

31. Date filed (Month, Day,

30. Name and ad

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dress of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 26 per verb., g912,02/16/2011dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hightower Charles Month Physician/ 2:00 1 M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A Examiner 4b. City, Town, or Location of Death 501 E. PRESTON ST. BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months Days Hours Min. 1 M 2 F 219-32-7005 72 Director MARYLAND -28 - 1939Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 □ No MD. N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 4112 E. EAGER ST. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: XXWidowed 4 Divorced BLACK Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12)
-12-College (1-4 or 5+) Mental Hygiene. of Health and Mental Hygiene item 27 is marked other the other traumatic event, the I -0-LABORER GENERAL MOTORS CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOSEPH REID LILLIAN HIGHTOWER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 MARVIN HIGHTOWER (SON) E. EAGER ST. BALTIMORE. MARYLAND 21205 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o ō 1 KBurial 2 Cremetion 3 Removal from State MT. ZÍON CÉMETERY 2-12-2011 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) HIBNER Name and Address of Facility REDD FUNERAL SERVICE Teral Service License CONATHAN D. Signatur 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a, Par nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock for heart failu Immediate Cause (Final or heart failure. List only one cause on each line. End-Stage Cardiomyupathy Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. ▼ We the Funeral Director. After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 🗌 No 2 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Residence Other: [교 1 Yes 2 🖺 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specif 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MS Rajapamin b. 29c. License number 29d. Date signed (Month, Day, Year) DO057465 2/10/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

amend #2 Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ Month Day 4a. Facility Name (if not institution, give street and number) Helwitt Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖊 F Months Days Hours Min 80 Yrs. Director Jan 19. 213-28-9588 1931 Maryland Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 7121 Chamberlain Road LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 \square Never Married 2 \square Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 x No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any higury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Government 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Gorman Catherine Burkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Collins / SISTER <u>6A Port West, Swansboro NC</u> 21854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2-9-2011 Metro Crematory TNC Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, IN Signatur of Funeral Se Patrik Fleming Frederick Road, Baltimore, MD 21228 Part 1. Enter the disease, or complicat ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ 0 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for se's consequence dry burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 N this certificate 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 10 2 No Other: 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 J-31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth M. Howe 4:40 a'5"11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Franklin Square
5. Social Security Number 1 6. Sex Baltimore rosedale Hospita Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X□ F Months Days Hours Min. Month Day, Year 1934 North Carolina Director 245-46-8750 76 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Middle River ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 13111 Cherwin Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married filed within 72 hours after "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Custom Canvas Seamstress Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is markec Earl Coyle Lillie King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hoffman, Daughter .3111 Cherwin Avenue Middle River, Maryland 21220 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 02/12/11 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. roma 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SYCLE disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner neumonia weeh Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last ardiac week Due to (or as a consequence of) attending physician for use as the buria Physician/Medical ocardia beeh Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 N death? certificate 2 🗆 No 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA After this 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work after death. Director: Aft 1 Tyes 2 🗆 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 5473b 11 2011

State Registrar 30. Name and add

31. Date filed (Month. Day, Year

ss of person who completed

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9000 Franklin Square Dr.

Baltimore

MD alasn

ause of death (Item 23a) (Type, Print)

MD

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 11:25 P M Lois Johnson Barbee Harker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Examiner TOWSON Joseph Medical Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 💢 F Days (Month, Day, March 1 212-22-9505 **Director** 93 Usual Residence of Deceden ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Rd. 21286 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🕅 No 3 X Widowed 4 Divorced Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) teacher education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hubert Lionel Barbee Angeline Regina Updike 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Halverstadt/P.O.A. 524 Limerick Cir. Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardFeb. 11,2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mitchell-Wiedereld Funeral Home, Inc. 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Se Physician 0515 disease or condition Medical resulting in death) Due to or as a consequence of): Tract Infection **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a cor or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death ed by the a q Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has l r this certificate has eral director, page 2 performed? Yes 2 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Hospital Other: ျပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

State
Registrar

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FEB 16 2011 32. Registrar's Signature

M.D

30_Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ February 69, 2011 **JOSEPH** MICHAEL HAMERNICK 7:46P Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris TImonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XXM 2 □ F Months Days Hours Min 0777671928 Director 579-66-8138 82 Connecticut Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 28a-f 1 Tes 2 XXNo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Priest Religious Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph M. H. Hamernick Margaret O'Rourke injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Rev Edward Glynn SJ 5704 Roland Avenue Baltimore, Marvland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOODSTOCK Cemetery 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State 02/14/2011 Woodstock, Maryland ☐ Donation 5 ☐ Other (Specify) ature of Funeral Se 22. Name and Address of Fachtitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Physician/ END STAGE DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 After this certificate has 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 2 No Accident Investigation after death Director: / n 24 hou. the Funeral Direc. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

FEBRUARY

JOSEPH HAMERNICK

TIMONIUM,

MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JUNECIA WHITE,

31. Date filed (Month, Day, Year) FEB 16 2011 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / State of Maryland /	-		of Health a of Death	and M		giene Reg. N	71111		102
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Tim	e of Death
	Physicia Medic		RUTH DeHOFF HAMPSHIRE					February	/ 13 ⁵ ,	^{ay} 2011 Year	2:26	<u>А</u> м
	Examin	er	4a. Facility Name (if not institution, give street and number) Emeritus			n, or Location o	of Death		40	Baltimo		
ı	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 1 M 2 XX F 94		If Under 1 \ Months D	ear If Under ays Hours		8. Date of Birl 04/03/19		g. Bi	thplace (Sta Warylan	te o <i>r Foreig</i> n (
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Loca	ation						10d. Inside	e City Limits
	Mary 28a-1 otifie	Director	Maryland Baltimore Towson		T							Yes 2 X No
	vith the 23a or st be i		10e. Street and Number 611 Coventry Road		10f. Zip Co	21286			10g. C	itizen of What C	ountry?	
	eath v tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces	13. W	as Decedent	of Hispanic Ori	gin? (Spec	cify Yes or No-		14. Race - Ame		1
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 St. No If Yes, Give Year or Dates.			No Specify:	i, Fuerto r	ican, etc.)		Black, White Specify:	e, etc. White	
2-0	2 hour "natu edical	plet	15. Decedent's Education 16a (Specify only highest grade completed)	(Give ki	ent's Usual O ind of work d	one during most	t of workin	ıg	16b. l	Kind of Business		
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Mai	2 sho Ith and 27 is r			_		reet and Numbe Road Ellic			-	r Town, State, Zi	p Code)	
ore,	of Heal		20a. Method of Disposition 20b. Place of	of Disposi	ition (Name o	f		ate Pio	-	ocation - City o	Town, State)
timo	Page trment o tant; If jury or		₩XX Burial 2 □ Cremation 3 □ Removal from State Druid R:	idge (Cemetery	/ (02/16/			sville, M		
Ball	permit. Departr Imports any inji		23/ Signature of Funeral Service Licenses Which Menakis	22.		ork Road (d Funeral d 21212	Home I	nc
			23a. Part 1. Enter the disease, o complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter	the mode of	dying, such as	cardiac or	respiratory an	rest,			Between
	Pnysician/ Medical	i	Immediate Cause (Final disease or condition resulting in death) a. De Cill Due to (or as a consequence	00.							44	nd Death
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	7 ×	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence	of):								
	ecutec and I-trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence resulting in death) Last Due to (or as a consequence	of):								
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876	rtificate ing phy e as th	/Med	IF FEMALE:									
ox 6	ath ce attend for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death		Ectopic preg					23d. Date of de Month	livery Day	Year
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of <	g Physer this eral di	e: To	27. Manner of Death 28a. Date of injury 28b.	Time of	28c.	4 L J N∟ Injury at		ne 5 🗌 Resid 8d. Describe h		Other (Spec ry occurred	cify)	net -
ono	eath. or: Aft	ficat	Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	injury		work? 1 Yes 2	No					
Division of Vital Records, P.O. Box 68	al or Att s after d il Direct	Certificate:	4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stree	et, factory, of	fice	2	8f. Location (S City or Tow		nd Number or Ru e)	ral Route No	umber,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my knowledge, (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one)	or investig	gation, in my	pinion, death oc	curred at 1	the time, date a	and place	e, and due to the	cause(s) and	manner stated.
	To the To the comp	2	29b. Signature and title of certifier	go, uc		cense number	and place		29d. Da	ate signed (Mont	h, Day, Year)	
			Marino		Ì,	1 28 50	03		fel	much	7 14	2011
_			30. Name and address of person who completed cause of death (Item 23a)	(Type, Pri	int) Cura	LS ST	7	msun	M	\sim		
	∌ Stat	e *	31. Date filed (Month, Day, Year) 32. Registrar's Signature				(2	7.470/4		")		
	Registra	ar	FEB 1 6 2011 General D. San	Kar								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Feb. Julia Mae Hansen 2011 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville Oakcrest Village 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 Days Country) Indiana Min. Months May, 24, 1923 87 Hours Director 317-16-0895 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at by Funeral Director **Baltimore** Parkville Maryland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 21234 8834 Walther Blvd. of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Homemaker Own Home Be other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Schwartz Iva M. Porter permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Hansen - Son 140 Rachel Lane, Berkley Springs, West Virginia 25411 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🛱 Cremation 3 🗌 Removal from State Feb. 13,2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility Evans Funeral Chapel and Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a se uence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of: attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by alzheimers Disease, CAO 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed^a after death.

Director: After this certificate Yes 2 No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 \square Yes 2V No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Dav. Year) 2/12/2011 chealle St R171944 CRUP MSN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michaelle G. Harrison 8500 Wolther Blud, 32. Regist ar's Signature State Registrar

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	Director		218-14-7164 Usual Residence of Decedent	1 XX M 2□F	87	Yrs.	Months Days	Hours Min.	08/14/	1923	Cour	mtry) MD
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lany	should and N is ma		19a. Informant's Name/Relations			19b. Mailin	g Address (Street a		al Route Numbe	er, City or T		
	nd 2 sealth m 27		BARRY HARRIS	'SON		456	2 ROLLING	MEADOWS	, ELLIC	COTT	CITY, MI	21043
ore	ge 1 a it of H if ite or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from State	20b. Pla	nce of Dispos	sition (Name of natory or other place	e)	Date		cation - City or To	own, State
Baltimore,	it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify)	AM		natory or other place ON CHIZUK EMETERY		3/2011		ALTIMORI	
Bal	permi Depar Impo any ir		21. Signature of Funeral Service Matt	Licensee			Name and Addres Name REIS	50			& BROS., VILLE, N	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02 Month Physician/ Helen Ann Hopkins 8:00 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Citizens Care Center Havre de Grace Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F 02/26/ 009-20-9759 76 Maryland **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Harford Maryland Havre de Grace 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 505 Congress Ave., Apt. 307 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Office Secretary æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Feeney Mary Malone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Cindy Wise / Daughter 342 Stockhams Lane, Aberdeen, MD 21001 20a. Method of Disposition
1 □ Burial 2 Û Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State West Chester, Ferris & Co. 2/11/2011 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Freeral S ^{22. Name and Address of Facility}
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Secure fielly list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 2 0 N Yes 25. Was case referred to medical Be 26. Place of De (h (Check anly ane) examiner? Other: 2 No 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manz-r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D(6)41 ZIIII 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** hard 2011 Dr. /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 7. Age (In yrs ast birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 □ F Min Months Days Hours 218 - 42 -2311 Isual Residence of Decedent 6 Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 1 Yes 2 No Director Baltimore atonsvi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1228 ral", or Items 23a Examiner must b Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No 21215-0036 Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hoartment Guard antment of Health and Mental Hyginortant: If item 27 is marked other Injury or other traumatic event, it land 18. Mother's Name (First, Middle, Maltien Surname) 17. Father's Name (First, Middle, Last, Be Albe ည Mary 19a. Informant's Name/Relationship (Type. Print) (Space) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Shirley 46 Contonsville MD 21228 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 9/2011 Baltimere 5 ☐ Other (Specify) 4 □ Donation 21. Signature Peral Service Licens Name and Address of Facility B1216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiratory **Physician** hronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed encephalopath Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Stroke Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy O DVI 2 No 10 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mulugeta
31. Date filed (Month, Day, Year) AKAL CHARLES

DHMH 17 Rev 1/2001

State

Registrar

BFFRES

2. Registrar's Signature

6

Tavon Johnson 11-01070

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		1- For State Registrar	St	ate of Maryla	and / E	Department of Certificate of		nd Men	ital Hyg		eg. No.	2011	04407
Physici		1. Decedent's Name	(First, Midd	le,Last)			_			Date of Dear	th Day	Year	3. Time of Death
Medical Exami	iner	Tavon 4a. Facility Name (if	Dwon	Johnson			I n on #	·	F	ebruary	7, 201 ⁻	1	1908 hrs
				ew Medical Cen			4b. City, Town, Baltimore	or Location o	or Death		40.	County of Deat	n
Funeral		5. Social Security N	umber	6. Sex	7. Age (Ir	n yrs. last birthday)	If Under 1 Ye	ear If Unde	er 24Hrs.	3. Date of Bir	th (MM/D		rthplace (State or
Director		217-21-71	07	1 M 2 F	23	R Y	Months Da	ays Hours	Min.	Jan. 2	24.1	988 Forei	^{gn} ^{Duntry)} Mary.land
		Usual Residence of			2.								
w any		10a. State	10b. County		100	c. City, Town or Loc	ation						10d, Inside City Limits
Maryland 28a-f sbow	to	Maryland	N/	A	E	Baltimore							1 Yes 2 No
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ith the	a D	1112 E.	36th S	treet 12. Was Dec	odont Eve	violls 13 M	21218 Vas Decedent of H		nin? / Snaci	fy Vac or No	USA		rican Indian, Black,
72 hours after death with the Maryland n "natural", nr items 23a or 28a-f sho al Examiner must be notified at once	Funeral Director	1 X Never Marrie	d 2 M	arried Armed F		lf.	Yes, specify Cub				` '	White, etc.	ican indian, black,
fler d		3 Widowed	4 Div	1 Yes orced If Yes, Give Yea		No 1	Yes 2 X N	lo specify:			s	Specify: Bl	ack
5-0036 led within 72 hours at dygene. other than "natural the Medical Examin	d by	15. Decedent's Edu	ucation (Spe	cify only highest grad	de comple	ted) 16a. Decede	ent's Usual Occup				16b. Ki	ind of Business/	Industry
n 72 h	Completed	Elementary/Secon		College (1	-4 or 5+)		9		use remed	,			
15-003(filed within 1 Hygiene. ed other tha	E O	12th gr 17. Father's Name (F		Laet)		Reta	ail Clerk		'a Nama (Fi	rst, Middle, N		d Navy	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	BeC	Jeffrey 5		,					ida Pa		naiden 3	ourname)	
2121 buld be fill Mental I marked ie event,	10	19a. Informant's Nan	ne/Relations	hip (Type, Print)		19b. Maili	ng Address (Stre				ber, City	y or Town, State	e, Zip Code)
Baltimore, MD 2 permit Pages and 2 shoul Department of Health and I Important: If item 27 is ur		Brenda Pa		Mother		1112	E. 36th	Stree	t Bal	timore	e.MD	21218	
Fe, s 1 and f Heal F item		20a. Method of Disport		3 Removal fr		20b. Place of Dispo crematory or o	osition (Name of c			ate	20c. Lo	ocation - City or	Town, State
Page nent o		4 Donation 5				Mt. Zion	Cemetery	7	2-15-	2011	Lans	sdowne,	MD
Baltimore, permit. Pages lar Department of Hee Important: If ite		21. Signature of Fun		Licensee	1		Name and Addre	ss of Facility	Chat	man-Ha	arris	s Funer	al Home
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Box 6876(e death certificate the attending phy ed for use as the t	sicial	past 12 months?		4 Pregn	ant at time	of death	other (Specify)	Letopie	programoy			nontra i	Day (ea.
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Sal	(-110-011-0111)		ysician: To the bes	-	_							
To the within 2 To the complet	Medical	2 👿		niner: On the basis of and manner st		tion and/or investiga			curred at the	time, date a			
	2	29b. Signature and tit	cie or certifier				29c. Licen	.M.E.				ate signed <i>(M</i> o uary 8, 2011	
	-	Tamely address	puth	all, MI	o of -1	/ltom 22-1		.191.1			, epit		
		30. Name and addres Pamela E. So					0 W. Baltimo	re Street.	Baltimo	re, MD 21	223		
Sta	ate	31. Date filed (Month,			strac's Si	gnature		-,					
Regist	_		FER 1	6 2011	-	1. 1	arked						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 9:46 am Cameron Amir 10 Johnson 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Brubar Court Woodlawn
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Balto 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F 4 214-77-5020 10-15-2006 MD Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Md 1 ☐Yes 2 No Balto Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4 Brubar Court 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Wever Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐Yes 2√XNo Specify: Black Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry na (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Johnson Stephanie L. Hines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie L. Hines-Mother Woodlawn, MD 21207 <u>Brabar Court</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Cher (Specify) Greenmount mount | 2-17-2011 Baltimore,
22. Name and Address of Facility March East F/H 21. Signature of Fune Service Lic 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Complication disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

executer use as the burial-tran P.O. Box 68760, physician pe attending ρ signed by the a Division of Vital Records, has been page 2 this certificate To the Hospital or Attending Physician: After thi death.

Examiner Physician/Medical þ Completed Be I Director; A

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, Ite Modical Evan for that be notified at

permit. Pages Department of Important: If It any Injury or o

Physician

/Medical

Examiner

altimore, Maryland 21215-0036

Certification: To

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within 24 hours a
To the Funeral I State

after

25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Institude, 801 North Broadway, Baltimore, MD 21205 Kennedy Krieger

February 14, 2011

D50714

B. Levey 31. Date filed (Month, Day, Year) FEB 16

Registrar

Registrar

State

FRanklin Saugre

DRIVE , Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1- For State

Please Type or Print in Black Indelible State of Maryland / Department of Certificate of Certifi	of Health and Mental H		201	04410
Name (First, Middle,Last) 21 len Johnston		Date of Death Month Day February 14,		3. Time of Death 0709 hrs
me (if not institution, give street and number) avenhurst Circle	4b. City, Town, or Location of Death Glen Arm		4c. County of Death Baltimore Cou	
rity Number 6 Sey 7 Age (In yrs last hirthday)	If Under 1 Year If Under 2/Hrs	R Date of Rirth/M	M/DD/VVVV 9 Rin	thnlace (State or

		Registrar						Reg. No.		
Physic	ian/	Decedent's Name (First, Middle,Last)					2. Date o Month		Vene	3. Time of Death
Medical Exam	niner	Mary Ellen Johnsto	n					ary 14, 20	Year 11	0709 hrs
		4a, Facility Name (if not institution, give s	treet and number)		4b. City, Town, o	r Location o			County of Deat	h
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Funera		5. Social Security Number 6. Sex	/. Age (In y	rs. last birthday)	If Under 1 Ye			,	Forei	rthplace (State or
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	•	Usual Residence of Decedent								
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Maryland 28a-f show d at once.	Director	10e, Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?
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2121; uld be fil Mental F marked	Be	Bruce Victor Moore				Elsi	.e		Kohler	
	ု ၉	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Stre	et and Num	ber or Rural Rout	e Number, City	or Town, State	e, Zip Code)
MD d 2 sho lth and n 27 is		Ms.Leslie E.Kinnar	d (Daughter	948	North Sh	nine A	we. Orl	ando. F	L. 3280	3-3330
		20a. Method of Disposition		Ob. Place of Dispos			Date	20c. L	ocation - City or	r Town, State
of H		1 Burial 2 Cremation 3					Wednesday	, E	larford	County)
Pag Pag ment bant:		4 Donation 5 Other Specify:		Cremetion:	Services,]	inc.	Feb. 16, 20	11 For	est Hi	ll,Maryland
Baltimore, permit. Pages I a Department of He Important: I'ite injury or other training or other train		21. Signature of Funeral Service Licensee	Jeffrey I. Ca	ir Sr 22.1	Name and Addres	ss of Facility	es Funeral			- 1 - D 3
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1	10						1. 🗀			

cause of death? y 4 🗸 Unknown sy findings available oletion of cause of To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certif completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natura! Pending 1 Yes 2 No 2 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedlcal Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. February 15, 2011

30. Name and address of person who completed cause of death (Item 23a)

OCME

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date Month 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:00pm **Physician** 2011 S /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel Severna Park Hearlands of Severna Park If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 05/01/1919 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** West Virginia Days Min. Months Hours 1ĂM 2□ F 91 233 16 3714 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County er than "natural", or items 23a or 28a-f show the Wedical Even inversigat by notified at 1 □Yes 2 No Director Anne Arundel Linthicum Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21090 307 Eva Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify If Yes. Give Specify: White Year or Dates: 3 XWidowed 4 ☐ Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene, item 27 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Railroad Locomotive Engineer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William R. Knight Dora E. Cain ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arnold, Maryland 21012 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 11 Roe Lane Ted Chwastyk / Guardian 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 02/11/2011 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the diseas, e., implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death 231. Part 1. Enter the disease Immediate Cause (Final da **Physician** oneumonio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) □Yes 2□No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð law requires 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 2 No 1 □ Yes e Hospital or Attending Physician: 1 24 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p Assisted 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) ၉ 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Certification: (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely Medi the the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 12 Registrar's Sig 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 14, 2011 Junior Mason Kauffer 12:45p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Aberdeen 699 Custis Street If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral 1**★★M 2 □ F Hours Country 0472471937 Director 230-42-8414 Virginia Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Aberdeen Maryland 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 699 Custis Street 21001 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 No 1 ☐ Yes 2 → No Specify: white Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Board of Education Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maude Keen Joseph Kauffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 699 Custis Street, Aberdeen, MD 21001 A. Marie Kauffer item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA R.A.Ferris & Company 2/16/2011 ²² Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001 21. Signature of Funeral Service Ligenses Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be a after death.

Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiners and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Praction To the basis of my included a part of man and at the time, date and place and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) D0063981 M.D. 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Havre cle Grace MD 21078 Benjamin Lee, 669 Revolution

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 16

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 14 2011 Albert Leo Knell Jr 4:45a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** (Month, Pay, Year)
December 10 1941 Baltimore, Maryland 1 🖫 M 2 🗆 F Days Months Hours 218 40 8499 69 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at Director 1 Yes 2 No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral USA or items 23a 21237 4809 Ridge Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 Yes 2 No Specify: White Specify: 'natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 | n and Mental Hygiene. 7 is marked other than "n within 72 College (1-4 or 5+) Elementary/Seconday (0-12) Auto Mechanic Auto Repair Industry N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Leo Knell Sr Susan Elizabeth Burkhardt permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5824 Deer Park Road Reisterstown, Maryland 21136 Christine M Roach Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory Inc February 19 2011 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Baltimore.Marvland 4 Donation 5 Other (Specify) g ature of Funeral Service Licensee 21 Assand Attineratione Inc 7401 Belair Road Baltimore, Maryland 21236 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and-tran Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical that the death certificate be Box 68760 the attending ph IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death the 9 Unknown P.O. | þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires to the law requires to the hours after death. 1 Yes 2 No 3 Probably 4 Mknown been signature should be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? icate has t performed certificate 1 Yes 2 No 1 🗆 Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: in Mospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred in 24 hours after death.

he Funeral Director: After to a pleted filled in by the funeral to a pleted filled in by the funeral pleted filled fil 28c. Injury at Certificate: 1 Natural 2 Accider 5 Pending work' 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one within 7 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES W 6701 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 16 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:00 A February 2011 Joseph Alvin King, Sr Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 1924 Frames Road Dunda1k 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 **x** xM 2 □ F 09-19-1949 Baltimore 213-52-4019 Yrs Director 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must ha marified at ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2XXNo Dunda1k MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral United States 21222 1924 Frames Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X X Yes 2 \(\square\) No Black, White, etc. 1 Never Married 2XXMarried 1971 Completed by Maryland 21215-0036 If Yes, Give Year or Dates Yes 2x No Specify: Specify: 3 Widowed 4 Divorced White 1972 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Ceramics Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donalene Scott Joseph A. King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1924 Frames Road, Dundalk, Maryland 21222 Shirley King - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Meadowridge Mem Park | 02-17-2011 Elkridge, Maryland 4 Donation 5 Other (Specify) Signiture of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ventricia Physician/ Mins disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Yes 2 No To the Hospira. ... within 24 hours after death.

To the Funeral Director: After this certificate has to completed filled in by the funeral director, page 2 should to complete filled in by the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 21 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ☐ Medical Examiner: On the pasis or examination and or investigation, it may optime, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

3 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 1

16

WI 30 Name and address of person who completed cause of death (Item 23a) (Type, Print 29c. License number

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mar bom Physician/ 30, 20 II atherine ring 1213 Januar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death General Hospi tal Howard County towar olumbia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🏝 F Days Hours 01-04-1937 New Jersey 144-28-5641 74 Yrs Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zin Code ō 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral 23a 10476 Sternwheel Place 21044 U.S.A. items ? be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with and Mental Hygien ris marked other th Registered Nurse Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 August Tavoso Mary Boggiano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Chris Kindbom (Son) 10 Wilderness Drive Medford, NJ 08055 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Arlington National Cem Unknown Arlington, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or c shock, or heart failure. Liet on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, therusclerotic Coronary Vascular Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. Examine cause. (Disease or linjury Due to (or as a somequence of, attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a be detached f 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ! autopsy certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) DØØ5 3312 January 30, 2011 MO enpleted cause of death (Item 23a) (Type, Print)
Linggeler, Mb 5755 Cedar Lane, Columbia, MO 21044 30. Name and address of person who c Henggeler Vichelle 31. Date filed (Month, Day, Year) State 6

DHMH 17 Rev 7/2009

Registrar

11-01109 James A. Kaylor

Please Type or Print in Black Indelible Ink. Ensure A State of Maryland / Department of Health and N	All Copies Are Legible.	0416
Certificate of Death	Reg. No.	
Laws (First Middle Loct)	2. Date of Death	Time of Death

		R	egistrar			Cerui	icate of	Dealii			[2.5		g. No.		3. Time of Death
Ph Jedical E	ıysicia Examir	ner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February 9, 2011 3. Time of Death O915 hrs												
			la. Facility Name (if not institution Mercy Hospital	n, give street and	number)			4b. City, To Baltimo		ocation of	Death		N/A		
	neral ector	- 1	5. Social Security Number 93-48-4591	6. Sex	7. Age (In	-	birthday)	If Under Months	1 Year Days	If Under Hours	1	Date of Bir 06/28	h(MM/DD/YYY /1962	Foreign	nplace (State or n ntry)Virginia
Đ	how any		Usual Residence of Decedent 10a. State 10b. County 10b. Anne	Arunde1	100	c. City, To	wn or Local	tion	Edg	ewate	er				10d. Inside City Limits 1 Yes 2 No
Marylan	items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number				-	10f. Zip C		1027		11	Og. Citizen of V United		
ith the	23a or notifie		3417 Swallowta		ecedent Eve	er in U.S.	13. Wa	as Deceden		21037 anic Origin	n? (Specif	y Yes or No			can Indian, Black,
and 2 should be filed within 72 hours after death with the Maryland	5 8	Fune	1 Never Married 2 M		Forces?		If Y	res, specify Yes 2	Cuban, I	Mexican, I	Puerto Rica	an, etc.)	Specify	ite, etc. : Wh	ite
hours af	Cxamin	ed by	15. Decedent's Education (Spe			ted) 16		nt's Usual O nost of work				done	16b. Kind of E	Business/Ir	ndustry
)36 thin 72	than "	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)		Bui1	.ding	Insp	ecto	r	9-	County	y Gov	ernment
21215-0036 yuld be filed within 7	Mental Hygene. marked other than "natural", event, the Medical Examiner.	Be Con	17. Father's Name (First, Middle Willard J.	, Last) Kaylor	_				- 1	3.Mother's Kati	,	st, Middle, I	Maiden Surnam	ne)	
213 should b	is marked atic event,	5	19a. Informant's Name/Relations Gloria Catever		tor	- 0							nber, City or To		
e, MD	nt of Health and it. If item 27 is a other traumatic	ŀ	20a. Method of Disposition					sition (Name				ate	20c. Location		
Baltimore,	nent of ant: If or or other		1 Burial 2 X Cremation 4 Donation 5 Other S	pecify:	9.5-5	Meti	co Cre	emator	-						Maryland
Baltil permit.	Department of Health and IN Important: If item 27 is m injury or other traumatie	- 1	21. Signature of Funeral Service	Lan '		,	29	99 Fre	deri	ick R	Rd., E	Baltim	ore, M	212	Maryland 28
Phys	ician		23a. Part I. Enter the disease, or failure. List only one cause	on each line.							rdiac or res	spiratory am	est, shock, or h	neart	Approximate Interval Between Onset and Death
	niner		Immediate Cause (Final disease or condition resulting in death)		ations of T s a consequ		stomy T	ube Plac	ement						- Bount
		Jē.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		s a consequ	ence of):									
M. euted	l ınsit	Examiner	(Disease or injury that initiated events resulting in death) Last	U	s a consequ	ence of):		_				 			
exe	g physician and s the burial - transit	n/Medical	UNPENDED	AMENDE	Đ			-							
8760, tificate be	ing physi as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in t		es, outcome	of pregna		etal death	3	Ectopic	pregnancy	,	23d. Date Month		/ Day Year
Box 61 e death cert	e attendin for use a	Physicia	past 12 months? 1 Yes 2 No 9 Ur		egnant at tim known	e of death	_ =	other (Spec	fy)		,				· · · · · · · · · · · · · · · · · · ·
P.O. E	signed by the attendi be detached for use		Part II. Other significant condi Quadriplegia, Epidul			ut not resu	ulting in the	underlying	cause gi	ven in Par	rt I.	1			the cause of death? pably 4 Unknown
rds, F	s been sign should be	Completed by	Quadriplegia, Epidul	ai abscess, L	apetes							24a. Was		o. Were au	topsy findings available completion of cause of
Division of Vital Records, salor Attending Physician: The law requir	cate has page 2 sh	ошо											rmed?	death? 1 ✓ Ye	
Ezi izi	certificate ector, page	BeC	25. Was case referred to medic examiner?	al Hospital:	7	- Tal-			17	20	(Check only		Residence 6	Other	
of Vil	After this funeral dir	유	1 Yes 2 No 27. Manner of Death	28a. D	Inpatient ate of Injury	2	R/Outpatie		<u>^_ </u>	y at Work	2 28	d Describe	how injury occi of tracheos	urred	
ion	after death. Director: Af	Certification:		estigation	onth Day, Year 9, 2011		0836 hrs			es 2	No pla	acement			ural Route Number, City
ViS or A	fter in by	烂	det	ild not be	Place of Injur		ne, farm, str	eet, factory,	office bu	ullaing, etc	4	or Town.			
EG	led led	동	4 Homicide				, death occ	urred at the	time da	te and pla	ace, and du	e to the cau	se(s) and man	ner as stat	ed.
Di the Hospital	hin 24 hours after death the Funeral Director: npletely filled in by the		29a. Certifier 1 Certifying	Physician: To the aminer: On the ba	sis of examir	nation and	d/or investig	ation, in my	opinion,	death oc	curred at th	ne time, date	e and place, an	d due to th	ne cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be	within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cert	29a. Certifier (Check only 1 Certifying I	aminer: On the ba and mann	sis of examir	nation and	d/or investig	ation, in my	opinion, License	death occ	curred at th	ne time, date	and place, and 29d. Date si	d due to th	ne cause(s)
	0		4 Homicide 29a. Certifying I Check only one) 2 Medical Ex 29b. Signature and title of certifying I Check only one)	aminer: On the ba and mann ier	sis of examir er stated	nation and	d/or investig	ation, in my	opinion,	death occ	curred at th	ne time, date	e and place, an	d due to th	ne cause(s)
	To the Funcral Completely filled		4 Homicide 29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	aminer: On the ba and mann ier n who completed	sis of examir er stated	nation and th (Item 2	3a) iner 90	ation, in my	License O.C.M	death occ number	curred at th	ne time, date	29d. Date si February	d due to th	ne cause(s)

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death 657 P Physician/ Medical 4c. County of Death 4a. Facility Name if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltmore Secour Bathmore Bon Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Numbe Funeral Min. (Month, Day, Year) 4-1-1945 Months 1 □ M 2 💢F Hours Director 15-84-4320 65 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 ¥ Yes 2 □ No na MD Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 204 N. Fremont Avenue Apt 1 21201 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. mentary/Seconday (0-12) College (1-4 or 5+) 12th grade Nurse permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Roche Gaskin Daisy Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 Corley Road Apt B 5 Balto, MD 21207 Kim Long-Niece Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Donation 5 ☐ Other (Specify) Zion Cemetery 2-15-2011 Lansdown, MD Mt 22. Name and Address of Facility March East F/H . Signature of Funeral Service License Balto, MD 21202 Ε. North Avenue 1101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each,line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events Due to (or as a conce resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 Yes 2 No this certificate 25. Was case referred to medical examiner?
1 🗸 Yes 2 🗆 No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA ည Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury 24 hours after death. Funeral Director: Af 2 Accident
3 Suicide Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and title of celtifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 S. Paca St. Baltimore, Md. 21201 Walesia Robinson 31. Date filed (Month, Day, Year) State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LEORA JUNE LYTLE 12:15 P M February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Center Towson Baltimore County Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🖫 F Days Hours Min Months Yrs Director 166-26-8717 1931 Pennslyvania June Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No <u>Marvland B</u>altimore County White Marsh 10f. Zip Code Street and Number 10g. Citizen of What Country? Funeral 11345 Pulaski Highway 21162 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Worker Telecommunications Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ William H. Rush Sarah Jane Thomas or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Deborah Gail Smith (Niece)</u> <u>727 Bethel Church Rd, Latrobe, PA 15650</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🄀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Jersey Cemetery 2/15/2011 Confluence, PA 15424 21. Signature of Funeral Service MITCHELL WIEDEFELD FUNERAL HOME INC Karlin 6500 York Road, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sushock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death signed by the a Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy perform 2 No 1 Tes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes မ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

24 hours after death сопретен within 2

> State Registrar

(Check

only one Signature

d title

Pay.

Name and address of person who completed cause of death (Item 23a) (Type, Pr

0(

32. Registrar's

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

10

certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

200

11-01190 Michael Lower

Physician Medical Examin

Funeral Director

	Please Type or Print in B								gib	le.		* 1 1 0
	State of Maryland	•			and	Menta	al Hy	giene		2 1		11:19
	1- For State Registrar	Certific	ate of	Death				F	Reg. N	O		
ın/	Decedent's Name (First, Middle,Last)						2	Date of De				3. Time of Death
ner	Michael William Lower	r						Month February		2011		1835 hrs
	4a. Facility Name (if not institution, give street and number)		4	4b. City, Tov	vn, or Lo	cation of	Death			4c. County of	Death	
	509 Edgevale Road			Baltimo	re						I/A	
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last bin	thday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	irth(M			thplace (State or
	216-50-9798 1 _X M 2□F	61	Yrs	Months	Days	Hours	Min.	March	14,	1949	Co	n Washington D
	Usual Residence of Decedent											
	10a. State 10b. County	10c. City, Town	or Locati	ion								10d. Inside City Limits
ō	Maryland N/A	Balt	imor	e								1 X Yes 2 No
ğ	10e. Street and Number			10f. Zip C	ode	_			10g. C	Citizen of Wha	at Cour	ntry?
Completed by Funeral Director	509 Edgevale Road				21	210				U.	S.A	1.
<u>ख</u>	11. Marital Status 12. Was Decedent							cify Yes or N	lo-			can Indian, Black,
핕	1 Never Married 2 X Married Armed Forces' 1 Yes 2	X No	l IT Y	es, specify (Juban, I	viexican, F	uerto H	ican, etc.)		White,	elc.	
Σ.	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1	Yes 2X	No	specify:					Whi	
9	15. Decedent's Education (Specify only highest grade cor			t's Usual Oc					16b	. Kind of Bus	iness/i	ndustry
ş	Elementary/Secondary (0-12) College (1-4 or	5+)	during m	ost of working	ig ille. L	ONOTU	se retire	u)				
ğ	5+ year	cs		Attor	ney					L	aw	
ဥ	17. Father's Name (First, Middle, Last)			-	18	.Mother's	Name (First, Middle	Maid	en Surname)		
Be (Jack Bates Lower					Mary				ble_		
မှ	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address	(Street a	and Numb	er or Ru	ral Route Nu	ımber,	City or Town	, State	, Zip Code)

Margarita Korell MD.

31. Date filed (Month, Day Year)

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be sotified at some injury or other transmatic event, the Medical Examiner must be sotified at some Baltimore, MD 21215-0036 Physician /Medical

xaminer

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

Jack Bates Lower			Mary	y Jar	ne Tru	ımble	
19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stre	et and Num				te, Zip Code)
Margaret G. Lower (wife)	50	9 Edgevale	Road	Balt	imore,	Maryland	21210
		Disposition (Name of co	emetery,	D	ate	20c. Location - City	or Town, State
1 Burial 2 X Cremation 3 Removal from State		y or other place)		0.1/	11	D 1. 1	v 1 1
	een	Mount Crema		2-14			, Maryland
21. Signature of Funeral Service Licensee		22. Name and Address Mitchell- 6500 Yor	ss of Facility Wiedei k Road	feld H	uneral Limore	Home Inc	d 21212
23a. Part Enter the disease, or complications that caused the death failure. List only one cause on each line.			g, such as c	ardiac or re	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Immediate Cause (Final disease a. Mitral Val		isease					_
bao to to as a someoquemes	ان).						
Sequentially list conditions, b	~f\:						
cause. Enter Underlying Cause	JI).						
(Disease or injury that initiated events resulting in death) Last	of):						
d.							
	per	me g914 4-	4-11	vt			
						23d. Date of delive	201
IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg		Fetal death 3	Ectopic	c pregnancy	,	Month	Day Year
past 12 months?	2 [eath 5	Other (Specify)		o p. eg. a ,			,
1 Yes 2 No 9 Unknown 9 Unknown	3 (Other (Specify)					
Part II. Other significant conditions contributing to death but not	resulting	in the underlying cause	given in Pa	art I.	23e. Did tob	acco use contribute	to the cause of death?
		,,,,,			1 Yes	2 No 3 Pr	obably 4 Unknown
					24a. Was a		autopsy findings available
					autops perforr		completion of cause of
1					1 ✓ Yes 2	No1 ✓	Yes 2 No
25. Was case referred to medical		26.Plac		(Check only	one)		
examiner? 1 Yes 2 No Hospital: 1 Inpatient 2] ER/Out	patient 3 DOA	Other ₄	Nursing H	lome 5 🔲 F	Residence 6 🗸 Oth	er: Scene
27. Manner of Death 28a. Date of Injury	28b. Ti	me of Injury 28c. Inj	ury at Work	? 28	d. Describe h	ow injury occurred	
1 X Natural 5 Pending (Month, Day, Year)		1	Yes 2	No			
2 Accident Investigation 28e, Place of Injury - At h	nome, farr	m. street, factory, office	building, et	c. 28	f, Location (St	treet and Number or I	Rural Route Number, City
Suicide 6 Could not be determined (Specify)		,			or Town, St		
4 Homicide	_						
(Check only							
and manner stated.	and/or inv			curred at tri	e time, date a		
29b. Signature and title of certifier		29c. Licer	nse number			29d. Date signed (A	fonth, Day, Year)
Mayente Philkrull		0.0	.M.E.			February 13, 2	011
30. Name an address of person who completed cause of death (Iter	m 23a)						

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

a.m.

10:45

FEBRUARY

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of

JACKIE

JONES,

2300 DULANEY VALLEY RD. 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year,

MD 21093

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

loward Little		1- For State Certificate of Deat			g. No.	12.1
Physicia	n/	1. Decedent's Name (First, Middle,Last)		Date of Death Month	n Dav Year	3. Time of Death 0000 hrs
Medical Examir		Howard Nelson Little 4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death	February 1	1, 2011 4c. County of Deat	
		1519 Shuresville Road Darlin			Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und Month 218-28-3736 1 X M 2 F 82 Yrs.	der 1 Year If Under 24Hrs hs Days Hours Min	8. Date of Birth April	14,1928 Forei	thplace (State or gn puntry) Maryland
	-	Usual Residence of Decedent				
w any		10a. State 10b. County 10c. City, Town or Location	-lington			10d. Inside City Limits 1 Yes 2 XNo
Maryland 28a-f show d at once.	١	Maryland Harford Dai	rlington		og. Citizen of What Cou	
th the Maryland 23a or 28a-f sho notified at once.	Öİ	2519 Shuresville Road	21034	τ	hited States	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 Married Armed Forces? If Yes, special Yes 2 No 1 Yes, Special Yes, Special Yes, Special Yes, Side Year 1 Yes, 2	lent of Hispanic Origin?(Sp ify Cuban, Mexican, Puerto 2 X No specify:	Rican, etc.)	White, etc. Specify:	
natura	og pe	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual during most of wo	l Occupation (Give kind of vorking life, DO NOT use reti	work done ired)	16b. Kind of Business	/Industry
36 in 72 h han "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Merch	ant Marine		Merchant	Marines
d withing greener the reference	mo;	Unk 17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M	faiden Surname)	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical)	Be	Archie Little			Cooper	
and 2 should be filed within and 2 should be filed within ealth and Mental Hygiene, ten 27 is marked other titraumatic event, the Med	P		s (Street and Number or cky Drive,			
e, MD	1	20a. Method of Disposition 20b. Place of Disposition (Na	ame of cemetery,	Date	20c. Location - City o	
15 C C C T		1 XBurial 2 Cremation 3 Removal from State Tabernacle 4 Donation 5 Other Specify: Cemete	Church 19	bruary , 2011	Whitefo	rd, MD
Balt permit Depart Impor injury		Evan	d Address of Facility s Funeral C woort Drive	hapel	& Cremati	on Services
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode	of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovasci	ular Disease			Death
		or condition resulting in death) Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ted Insit	Exar	events resulting in death) Last Due to (or as a consequence of):				
execuian and	Medical	UNPENDED AMENDED				
760, cate be physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 1 1 1 ive high	. De		23d. Date of delive	
Box 687 e death certific the attending I ed for use as the	Physician/	past 12 months? 1 Live birth 2 Fetal death 5 Other (Spi		lancy	Month	Day Year
BOy ie death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown	Dett.	1220 Didte	bacco use contribute t	o the cause of death?
that th	by P		ig cause given in Part I.			obably 4 🗹 Unknown
ds, equires	Completed			24a. Was		autopsy findings available
e law r e has b	ם			autop perfo	med? death?	completion of cause of
I Re			26.Place of Death (Check			
Vita hysicia this ce	To Be	1 V Yes 2 No			Residence 6 🗸 Oth	er: Scene
n of ding P		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d Describe	how injury occurred	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor		28f. Location (3 or Town, 5		Rural Route Number, City
bou hou y fill			he time, date and place, an	d due to the caus	se(s) and manner as st	ated.
To the Ho within 24 To the Fu	Medical	one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in n and manner stated.		at the time, date		
	×	29b. Signature and title of certifier	9c. License number O.C.M.E.		29d. Date signed (No. February 15, 20	
¥ (30 Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Ba	altimore Street, Balti	more, MD 21	223	
S	tate					
Regis		FEB 1 6 2011 June B. Sant			OOME	
DHMH 17 Rev 1/2	001	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 5:30 P. M Raymond Murray Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Levindale Rehabilitation Center Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F (Month, Day, Hours Marvland 65 June .1945 Director 218-42-1092 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director Examiner must be notified 1 ¥ Yes 2 □ No N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21239 USA 1915 Woodbourne Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Specify:Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Realtor years Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eleanor Raymond Murray Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2003 Hillenwood Road Baltimore, MD 21239 Gina McNeil/Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🏝 Burial 2 □ Cremation 3 □ Removal from State Woodlawn, MD 2-14-2011 4 Donation 5 Other (Specify) King Memorial Park 22. Name and Address of Facility Chauman-Harris Funeral Home Signature of Funeral Service Licenses 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ BOWEL SMALL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown HYPERTERISION 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has t funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Anatural 5 Pending 1 🗌 Yes 2 🔲 No Accident Suicide Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Darw H. WOWEHHINT 10063327 Feb. 07, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLDEHOUT, MD, 2324 W. Belveder Ave, BALTIMOVE, MD 21215 31. Date filed (Month, Day; Year) 32. Ragistrar's Signature State Registrar 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	of Marylan					Mental Hy	giene	9	61122
			Registrar		-41		Cer	tificate of	Death	1	_	Reg. N	0.	1423
	Physicia	n/	Decedent's Name (First,								2. Date of De Month Fcbruo		ay Year	3. Time of Death
-	Medic	al	Rache 1 4a. Facility Name (if not ins		McAfee			4b. City, Town, o	- I sootis	n of Door			c. County of Deat	
	Examin	er	Citizens	-			00	1-1 avr				41	1-1arf	
	Funeral	8 .	5. Social Security Number	6. \$		7. Age (In yrs. k		If Under 1 Year	If Und	er 24 Hrs	8. Date of Bir	th	9. Bir	thplace (State or Foreign
	Director		426-52-5427	1	X M 2 □ F	86	Yrs.	Months Days	Hours	Min.	(Month, Da March 2	y, Year) 8	1924 Mi	untry) SSISSIPPI
	t ow		Usual Residence of Deced	ent County		100 Cit	y, Town or Lo	otion						10d. Inside City Limits
	rylan I-f sh ied a	cto	Tour State		a		Aberde							MX Yes 2 □ No
	ne Ma or 28a notif	Director	10e. Street and Number	larior	<u> </u>		ADCIGO	10f. Zip Code				10a. C	itizen of What Co	
	with th	eral	113 Popla	ar Hil	1 Rd.			210	01			.og. c	USA	,
	eath v tems er mu	Funeral	11. Marital Status	1111	12. Was Dece	edent Ever in U.S	S. 13. V	Vas Decedent of F	Hispanic (Origin? (S	specify Yes or No-		14. Race - Ame	
9	fter d , or i	þ	1 Never Married 2		Armed Fo 1 Yes If Yes, Giv	2 🔀 No	- 1	Yes, specify Cub			to nican, etc.)		Black, White	
Ö	filed within 72 hours after death with the Maryland all Hygiene. all Hygiener than "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Completed	3 🔀 Widowed 4 🗆 D		Year or Da									o American
7.	72 hd n "na Nedic	lg l	(Specify on		ade completed)		(Give I	ent's Usual Occu kind of work done O NOT use retired	during m	ost of wo	orking	16b.	Kind of Business	Industry
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<u>ğ</u>	iled v Il Hyg othe		17. Father's Name (First, N	liddle, Last)					18. Mc	other's Na	ıme (First, Middle,	Maider	Surname)	
/ar	d be f Menta arked	입	Crawford	Cole					Ma	ude	Foster			
Maryland 21215-0036	should be and Ment is marked raumatic e		19a. Informant's Name/Re	lationship (T	vpe, Print)		1				ural Route Numbe			o Code)
	and 2 Health em 27 ther tr		Stevie McAfe		on)	T			ill R	d.,_	Aberdeer	_		
Baltimore.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispositior 1 ☐ Burial 2 😿 Cre		Removal from	State C	emetery, cren	sition (Name of natory or other pla			Date		Location - City or	,
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Ba	permit. Departr Imports any inji	J	21. Signature of Funeral S	Dry	JUN.	glesk	200	. Name and Addre		'I'a	rring-Ca	rgo	Funeral	Home, P.A.
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PRIL	be executed sician and burial-trans	Examiner	that initiated events resulting in death) Last	1	c. Due to	(or as a consequ	uerice of):	mw c	11800	n				
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C 92	ficate g phys as the	Med	IE EENAN E	- 100										
CC 7 x 687	that the death certificated by the attending particular of the detached for use as		IF FEMALE: 23b. Was decedent pregna		23c. If yes, out	tcome of pregna Birth 2 Feta	ncy al death 3 [Ectopic pregnar	ncv				23d. Date of de	
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Vita	/sicia s cert direct	To Be	examiner?	> 17	Hospital:	Inpatient 2 🗆	ER/Outpatier	_ Ott	her:	1	Home 5 🗆 Resi	dence	6 ☐ Other (Spec	cifv)
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on	endin sath. or: Aff	fica	2 Accident	Pending Investigation	1	ar, Day, Today	,,	M 1 🗆	Yes 2	□No				
Division of Vital	or Att fter d irecta n by t	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	of Injury - At ho ing, etc. (Specify		et, factory, office			28f. Location (City or Tou	Street a vn, Stat	nd Number or Ru e)	ral Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as		ode Oestine		plaine: To the 1	ant of multi-	lodge de-th	ocured at the star-	o data	ad sla ==	and due to the ca	nico(s)	and manner on the	ated
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	To the ∧ithin Fo the >ompl	Σ	only one) 3 L Ce 29b. Signature and title of			TO THE DESCOLUTE	, Milovijeuge, (29c. Licens			allo dde to ti		ate signed (Mont	
	- > - 0		> H180	VP4M	Min			1)4	641			2	11411	
	J		30. Name and address of	person who	completed caus	se of death (Item	1 23a) (Type, F	rint)		A 1 -	a		1 11	-
	۷۱		Mr sw 4	7/12	M	terns	an	Y10-6	(1	rin	Note			
	Stat		31. Date filed (Month Page	16 2	011 32.5	Registrar's Signa	ture	a stal						
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State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar	Cer	tificate of L	Death	,	Reg. No.		46
	Physicia Medic		1. Decedent's Name (First, Middle, Last) MILDRED MA	RTT	N		2. Date of Dea		2011	3. Time of Death
	Examir		4a. Facility Name (if not institution, give street and number) 7143 Greenwood Avenue			r Location of Death re County			unty of Death Baltimore	,
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt Month Day May 28	h	9. Birthp	lace (State or Foreign burg, Marylan
	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 23a-f show ite event, the Medical Examiner must be notified at	Funeral Director		ty, Town or Loc			1	10g. Citizer	1 of What Coun	0d. Inside City Limits 1 ☐ Yes 2 🗓 🛪 o try?
	th with the The Sa	ineral	7143 Greenwood Avenue	a Liai	21206			US/		
020	ırs after dea ıral", or itei I Examiner	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒️Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒️No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba I □ Yes 2 文文	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		Race - America Black, White, e ecify: Wh	
9500-61212	vithin 72 hou lene. I r than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A	(Give I	O NOT use retired)	during most of work	ing		of Business Inc	
Maryland	should be filed with and Mental Hygier is marked other t ranmatic event, th	To Be	17. Father's Name (First, Middle, Last) Conrad Haberlein	TOTOTO	JNOT	18. Mother's Nam Edith Jer				
_	ge 1 and 2 should be it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Raymond F Martin			and Number or Run Avenue Ba]				Code)
saitimore,	permit. Page 1 an Department of He Important: If iten any injury or otho	15	1 XXeurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren	sition (Name of natory or other place F Faith Cen	etery Feb.	Date 15 2011		tion - City or To	
gal	permit Depart Impor any in		21. Sixurure of Funeral Service Licensee	² 1	Name and Addre Lassahn Fun Baltimore,	ss of Facility Teral Home 1 Maryland 21	inc 74 236	01 Bela	air Road	
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	Examiner	niner	Sequentially list conditions, if any, leading to immediate course the standing of Cause (Disease or ilinjury	uence of):						
-	ificate be executed ng physician and as the burial-transit	Medical Examiner	that inflated events resulting in death) Last c. Due to (or as a consequence of the cons	uence of):						
BOX 68/60		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown IF FEMALE: 23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 🗌	Ectopic pregnand Other (specify)	су		230	d. Date of delive	ery Day Year
JS, P.O.	requires that the death cer been signed by the attendi should be detached for use	þ	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I.				e cause of death?
Records,	The law rec cate has bee page 2 sho	Completed					24a. Was autop perfo 1 Yes	rmed?	24b. Were autop prior to cor death? 1 \(\sum Yes	osy findings available impletion of cause of 2 No
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VISION OF	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Urrector After this certificate has completed filled in by the funeral director, page 2.	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	y at	28d. Describe h			
DIVISI	tal or Atter is after de al cirecte ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ht building, etc. (Specify		eet, factory, office		28f. Location (S City or Tow		umber or Rural	Route Number,
	he Hospi in 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check only one) 1	n and/or invest	tigation, in my opinio	on, death occurred a	t the time, date a	nd place, an	d due to the cau	use(s) and manner stated.
b	Vith Vith Con	100	29b. Signature and title of certifier	M	2 29c. Licens	5873		29d. Date s	igned (Month, L	Day, Year)
			30. Name and address of person who completed cause of death (Item 144640 BcB 6934	1 23a) (Type, P	rint)	Bluk	5,7	o A	121	1061
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture	NJ / C					

DHMH 17 Rev 7/2009

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AMEND ITEM#8perffi, G915, 5/2/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) JOseph Edward McCarthy Physician/ 2011 Р February 9 :04 Medical 4c. County of Death Anne Arundel 4b. City, Town, or Location of Death Annopolis 4a. Facility Name (if not institution, give street and number)
Anne Arundel General Hospital Examiner 8. Date of Birti 9-17-1929 9. Birthplace (State or Foreign (Month, Day, Year) Country)
9/24/1929 MAry Land If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 81 yrs. 5. Social Security Number 216-24-8400 **Funeral** 1**X**☐M 2 ☐ F Days Hours Min **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 🗆 Yes 2 No Maryland Queen Anne Stevensville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21666 412 Stafford Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1XX Yes 2 No
If Yes, Give Army 49-53
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Specify: 3 ¥ Widowed 4 ☐ Divorced Completed 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Circuit Court Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret D. Tribbe Joseph J. McCarthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) G-4300 Kalar Rd., Niagra Falls, Ontario, L2H158 Patricia A. Murchison/Daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🔏 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2/13/2011 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 21. Signatur of Funeral Service Licensee 7250 Washington Blvd.,Elkridge,Maryland 21075 au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. d Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate course Enter Unaurlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed it Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 💢 Inpatient 2 🗆 ER/Outpatient 3 DOA ပ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Doath 1 Natural 5 Pending 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ms who completed cause of death (Item 23a) (Type, Print) and address of person 50 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Clara moore 5:21P Leonary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🕅 F Months Days 3-14-1920 NC Director 90 237**-**24-4479 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Catonsville Baltimore MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21228 USA 1525 N. Rolling Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 20 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Specify: African-American 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed 12th Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Beatrice Peed Major Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1747 Champlain Drive, Apt. E, Baltimore, MD 21207 Darlene E. White/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 2-18-2011 Baltimore, Maryland Loudon Park Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility Wile Fineral Form P.A. of Raltimore Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 (Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cardioThrombotic event disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 4 Nursing Home 5 Residence 6 other (Specify) Hospital: Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Qutpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after de le Funeral Directo pleted filled in by th Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ns/lujapalmem.D DO05 7 465 2/12/11

Registrar
DHMH 17 Rev 7/2009

State

5-203

Baltimore, MDZ1207

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith AV

32. Registrar's Signature

NJ. Rajapakse MO 2835

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland / Depa				2.0	1	01.1.27		
			Registrar 1. Decedent's Name (First, Middle	tificate of D	<i>Jeann</i>	2. Date of Deat	eath 3. Time of Death						
	Physicia			Month Februa			Day Year		9:00 A M				
	Medic Examin			Jane Elizabeth McCarthy 4a. Facility Name (if not institution, give street and number)				TCDLGGL	4c. County of Death				
			92 Newport Dri	Berlin	4b. City, Town, or Location of Death Berlin				Worcester				
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	lace (State or Foreign		
	Director		216-58-6679	1 □ M 2 💢 F	51 Yrs.	World Buys	Tiodio Mini.	1270971	.959	Washi	ington, DC		
	how at	=	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10	Od. Inside City Limits		
	anylar la-f s	Director	MD Word	ester	Berlin						1 ☐ Yes 2 🔀 No		
	or 28	늅	10e. Street and Number	<u> </u>	Detiti	10f. Zip Code		1	0g. Citizen of \	What Count	try?		
	after death with I", or items 23a caminer must b	Funeral	92 Newport Drive 21811						U.S.A.				
		ᇤ	11. Marital Status	12. Was Decedent Armed Forces'		Vas Dece d ent of Hi f Yes, specify Cuba			14. Rac	e - America			
36		To Be Completed by	1 X Never Married 2 Mar	ried 1 Yes 2	đ No	Yes 2 X No		1 110011, 0101,	Specify:	k, White, e נילוד			
21215-0036	ours atura		3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation					-	· · Willec				
15	n "na Media		15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)						usiness ind	lustry			
212	within giene. er the		Elementary/Seconday (0-12)	College (1-4 or		hnology_C	peration	s	Ban	king			
pu	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampirity or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle,	Last)			18. Mother's Nam	e (First, Middle, M	laiden Surname	∌)			
Maryland			John Rexf		Carthy		Monica		Mulv	rey			
Nar			19a. Informant's Name/Relations			ng Address (Street a			•	State, Zip C	ode)		
			Monica M. McCa 20a. Method of Disposition	rthy / Mothe	20b. Place of Dispo	ewport Dr	- i		21811 20c. Location -	Oit T-	04-4-		
Baltimore,	age 1 int of t If it		1 🗆 Burial 2 🗆 Cremation		e cemetery, cren	natory or other plac	e)			•			
Ē	artmen artmen ortand injury		4 X Donation 5 ☐ Other (3	Δ	Anatomy Gif	. Name and Addres		4/2011 : Anatomy (
B	permit Depar Impor any in		1 SOF	1						-	•		
	,		7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CHRONIC 123114 FALURE a. CHRONIC 123114 FALURE Onset and Deat										
	Medical		resulting in death)	a. Due to (or as	a consequence of):	7770	. 0 1 6 6 6 6						
	Examiner	<u>_</u>	Sequentially list conditions,	b. TWE									
	icate be executed physician and s the burial-transit	Examiner	transplantation and the control of t										
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0	• Attending Physician; The law requires that the death certificate be executed all red death. • The transfer that this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	dical											
209	icate p physis the	ı w		d									
89	ath certifica attending p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome] F-4i			23d. Da	te of delive	ry		
Box 687	death le atte	Physician/M	in the past 12 months? 1 🔲 Yes 2 🔽 No	1 Yes 2 No 4 Pregnant at time of death 5 Uther (specify)						nth	Day Year		
P.O. I	hat the de ed by the detached	Phy	9 Unknown				1. D. 11						
σ.	ss that igned be de	þ	Part II. Other significant condition	ons contributing to death	but not resulting in the u	nderlying cause giv				id tobacco use contribute to the cause of death? ☐ Yes 2 No 3 Probably 4 Unknown			
rds	requires the been signed should be of	Completed		-46-7-1-7				1 □ Ye					
ပ္တ	has b	mpk							24a. Was an autopsy autopsy performed? 24b. Were autopsy findings avail prior to completion of cause death?				
Ä	sician: The law certificate has b lirector, page 2 s		25. Was case referred to medical	-1				1 ☐ Yes 2		1 Yes	2 🗌 No		
/ita	sicial certi	To Be	examiner? 1 Yes 2 No	Hospital:	hit 0 [[[[[[[[[[[[[[[[[[Othe	ace of Death (Chec	/	a 🗆 au	<i>(</i> 2)			
of\	ding Physi th. After this o funeral dir		27. Manner of Death	28a. Date of inj		28c. Injury	at	ome 5 🗹 Reside 28d. Describe ho		•			
U.	eth. r. Afte	icat	1 Natural 5 Pendii 2 Accident Investi		ay, Ye <i>ar</i>) injury	M 1 🗆	? Yes 2□No						
Division of Vital Records,	a er deal Director In by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ā	urs a ral Di												
	To the Hospital or Attene within 24 hours all er deatl To the Funeral Director completed filled in by the	Medical	29a. Certifier (Check (
	To the within 2 To the comple	ž	only one) , 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
										12,201/			
			30. Name and address of person		death (Item 23a) (Type, P			0	0 -		22161		
				ANDO MI	death (Item 23a) (Type, P	NU OLE	THVCIT	TEVD	15024	116, MI	021811		
	Stat		31. Date filed (Month Dy, Dear	6 2011 32. Fegist	rar's Signature	land !							
	Registra	alf			m 14. 14	work							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JR. ^{Year} 201 4:06Am **JOHN EDWARD** MARTANCIK FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days Hours Apy 11, 06, Year 948 1 XX X1 2 - F New dersey 158-36-3886 62 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1**XX**Yes 2 □ No New Jerselv Morris Boonton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 913 Boyle Street 07005 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates if Health and Mental Hygiene. Item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Caterer Catering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Martancik Janet Mary Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Carol Lee Martancik Wife 913 Boyle Street Boonton, New Jersey 07005 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 🏋 remation 3 ☐ Removal from State 02/18/2011 Rosedale Crematory ☐ Donation 5 ☐ Other (Specify) Orange, New Jersey 22. Name and Address of FMiltchell-Wiedefeld Funeral Home Inc 6500 York. Road Baltimore, Maryland 21212 ignature of Fun 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been simpled to the continuous of the continuous o the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION autopsy 1 ☐ Yes 2 ☐ No ☐ Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No ဂ္ 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury XNatural work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Territoring Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number D 39215

State

Registrar

7601

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mus

M.D.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUNNINGHAM,

31. Date filed (Month, Day, Year)

FEB 1 6 2011

13

OSLER DRIVE, TOWSON, MARYLAND 21204

2011

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c PER FH G912 2/22/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day Year 2100 PM **Physician** Mc Duffie 02 2011 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Randallstown Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 1 M 2 □ F 212 - 48 - 45 41 11/15/1947 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Randallstown Director MD the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 3 Virunga Court-Apt. H USA 21244 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainer. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Antorican 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of andustry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Elementary/Secondary (0-12) College (1-4or 5+) Mechnic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew McDuffy 2 Clarie McDuffy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virunga Court-Apt.H, Randallstown, MD 244 Naomi Winder/Sister Balltimore, MDn, State 20b. Place of Disposition (Name of 20a. Method of Disposition 271972011 Bayview Crematory 1 Burial 2 XX remation 3 □Removal from State Pikesville, MD Ridge Cem. Druid #ElDonation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Furier Service I Hari P. Close F.Svs, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approsited Course (Figure List only one cause on each line. Immediate Cause (Final Metastatic Prostate Physician cancar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failure to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physician and as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FFMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an rector, page 2 s autopsy performed? Yes 2 🖾 No director, 25. Was case referred to medical examiner? 26. Place of Death | Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 X Natural n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A.BJG 02/15/2011 D71493

Registrar
DHMH 17 Rev 1/2001

State

MD

Randallstown

21133

Liberty

back

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B020181

Year)

Pate filed (Month)

9109

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Adolphus O. Ben Nwaodo 7:28 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore City N/A 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 15, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min Director 73 N/A 1937 Alaenyi Ogwa Known as - Nwado, Adolphu:
Baltimore, Maryland 21215-0036 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified 1 ☐ Yes 2 1 No Maryland Baltimore Windsor Mill 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7600 Reserve Circle Apt. 303 21244 Nigeria items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 X Married 1 ☐ Yes 2 ANo Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meagnes. Elementary/Seconday (0-12) College (1-4 or 5+) Business Entrepreneur <u>6th grade</u> Ovenga Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ben Nwaodo Bessy Ihenacho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Ben/Daughter 7600 Reserve Circle Apt. 303 Windsor Mill.MD 21244 20a. Method of Disposition Unit 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Ogwa Imo, Nigeria 20b. Place of Disposition (Name of 5/20/Ï1 Famility, Compound place) 4 ☐ Donation 5 ☐ Other (Specify) -Unk Signature of Funeral Service Licensée Chatman-Harris Funeral Home 22. Name and Address of Facility 5240 Reisterstown Road Baltimore, MD 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Necrotic ischemie disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by epilepticus, shingles, atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has porthyridism autopsy performed? GERD Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License number Res - 000 23,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinci Hospital Surafit حياج D 31. Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

new

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No.													
-			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Reg. No.		3. Time of Death		
	Physicia		NORMAN ARCHIBALD NEIL						Month Februar	y 4,20	$oldsymbol{1}^{ ext{Year}}$	2111 hrs™	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. Coun	4c. County of Death Prince George's			
-pra			Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last b)	Clinton			If Under 24 Hrs.		8. Date of Birt			rthplace (State or Foreign	
	Funeral Director		579-74-3562 1 x M 2 □ F 67	Yrs.	Months	Days	Hours	Min.	July 5	1943	Jama		
	T NO H		Usual Residence of Decedent 10a. State 10b. County 10c. City, To.	our or Los	ation							10d. Inside City Limits	
	arylan a-f sh fied a	To Be Completed by Funeral Director	Maryland Prince George's Oxon		Zation							1 😾 Yes 2 🗆 No	
	or 28		10e. Street and Number		10f. Zip Code					10g. Citizen o	f What Co	untry?	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		7405 Abbington Drive	20745-1508					<u> </u>	United	State	es	
920			11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indi Black, White, etc. Specify: Black							e, etc.		
5-0 -0	2 hour "natu		15. Decedent's Education 1 (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working					ıg	16b. Kind of Business Industry			
12	thin 7%		Elementary/Seconday (0-12) College (1-4 or 5+)		life. DO NOT use retired)					Private			
Q 2	ed wit Hygie other ent, th		17. Father's Name (First, Middle, Last)	Marte	OF	Т	18. Mother	's Name	(First, Middle,				
an	be file ental rked c		Easton Neil				Mari	ie L	inton		_		
Maryland 21215-0036	d 2 should ealth and M n 27 is m a er trauma		19a. Informant's Name/Relationship (Type, Print) Lana P. Neil/Wife	19b. Mailin 7405	g Address (S Abbin	Street a	nd Number Dr.,	or Rural	Route Numbe	r, City or Town	State, Zip Land	20745-1508	
Baltimore,	ye 1 and it of Hei if item or othe		1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State	etery, crem	sition (Name natory or oth	er place			ary 12,	20c. Location	•		
Ē	artmer artmer ortant injury		4 Donation 5 Other (Specify) 21. Signature of peneral Solvice Licensee Donald R Gray		s Ceme		-	2011 Robe		Ft Was		on MD 1 Home Inc	
Ba	Dep Imp any) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	- 1					SE,Wash				
art;	Physician/		23a. Part 1. E/ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck. / rheart failure. List only he cause on each line. Approximate Interval Between Or set an Death disease or condition a WITHUS SULVALLE C										
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):						(m knows			
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Box 687	death certific the attending hed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal de 1 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic produced Other (spe		У				Date of del Month	livery Day Year	
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ita	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 FB			Othe	ace of Death				Al (O	:4.4	
n of V	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ate: To	27. Mann Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year)	8b. Time of injury	28	c. Injury work'	at ?	2	me 5 Resi			<u> </u>	
Division of Vital Records,		Certificate:	2 ☐ Accident	э, farm, stre						n (Street and Number or Rural Route Number, rown, State)			
Ω	e Hospital 124 hours e Funeral leted filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nursé Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
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	3		30. Name and address of person who completed cause of eath (Item 23	1 25	Print)	2 3	28	cl	Intan	5 M)2	0735-	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	1. 6	arke	3							

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		_ 1	State Registrar			Cei	tificate of L	Death		Reg. No.		
Ī	Physicia Medic		1. Decedent's Name (First, Middle, Gary Evere		vell				2. Date of De Month Febru		2 ^{Vea} r11	3. Time of Death 2:05 A M
	Examin	_	4a. Facility Name (if not institution, g	ive street and number)			4b. City, Town, o	r Location of Death			nty of Death	
			Gilchrist Hosp				Towsor				timore	
	Funeral Director		026-36-2412	. Sex 1 😿 M 2 □ F	ige (In yrs. Ia 63		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09/28		9. Birthp Count Massa	lace (State or Foreigr try) achusetts
	and show d at	l 1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				1/	0d. Inside City Limits
	r 28a-f notifie	Funeral Director	MD Howa:	rd	El	kridge	10f. Zip Code		1	10g, Citizen o	of What Coun	1 Yes 2 No
	vith th	iral	6779 Old Water	loo Road. :	±606		21075			U.S.A	١.	
	eath v	ű	11. Marital Status	12. Was Deceden	t Ever in U.S	3. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. R	ace - America	
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ठ	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates.			f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto Specify:	нісап, етс.)	Spec	lack, White, e ify: V	_{tc.} √hite
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Mar	2 shot th and 7 is n		19a. Informant's Name/Relationship					and Number or Rui				
	and and the Healt tem 2		Janice Newell 20a. Method of Disposition	/ Wife	20b. P	lace of Dispo	sition (Name of		Date		on - City or To	
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		1 Burial 2 Cremation 3 4 🔀 Donation 5 D Other (Sp		te o	emetery, crei	matory or other pla ts Registr			Hanove	r. Mai	rvland
葦	permit. Pag Departmen Important: any injury o		21. Signature of Foheral Service Lice	1	1231100			ess of Facility A				
ñ	any per		BOX	1				elley Dr.			over, N	MD 21076
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 🗔 Feta t at time of c	al death 3	Ectopic pregnar Other (specify)	icy			Date of delive	ery Day Year
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ί	Physi this c	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inp 28a. Date of in		ER/Outpatie	nt 3 🗆 DOA	4 L. Nursing F	lome 5 Res	how injury occ		11030.00
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Division of Vital Records,	or Atten after deal Director: in by the	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 28e. Place of I	njury - At ho etc. (Specify		reet, factory, office			(Street and Nur wn, State)	nber or Rural	l Route Number,
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•	To th within To th comp	2	29b. Signature and title of certifier	my Al	4 , 6	no	29c. Licen:	he time, date and pl se number		29d. Date sig	ned (Month,	Day, Year)
	•		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type,	Print) Prints St	, Balta U	nd 20	204		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture	 					
DU	Registr		FEB 1 6 2011	Brack	<i>A</i> .	face				·		

		1- For State Certificate of Death Registrar	_	ے۔ g. No.	
Physician Medical Examine	1	1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death 1215 hrs
Incurcar Examine		William Joseph Neumann, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	February 1	4c. County of Deat	
I I		8800 Walther Boulevard #4115 Parkville		Baltimore Cor	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	1.	h(MM/DD/YYYY) 9. Bii Forei	an
	-	218-28-6672 1XM 2F 78 Yrs. Usual Residence of Decedent	June 02,	, 1932	Maryland
any .	Ī	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
-f show	<u>.</u>	Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code	Lio	0.00	1 Yes 2 No
the Maryland a or 28a-f sh iffied at once	3	10e. Street and Number 10f. Zip Code 8800 Walther Blvd Apt #4115 21234	10	g. Citizen of What Cou United S	
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5-0036 ed within 72 hour lygiene. other than "matt	1	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret	ired)		
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21215-0036 Motal Bygene. marked other than "natural", or items cevent, the Medical Examiner must be		77'33'	eret Ch	,	
D 21 hould then is mar is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Rural Route Numl	ber, City or Town, State	- 43
and 2 sho ealth and tem 27 is traumati	+	Marylee Hormes (Sister) 12005 Cedar Lane F	Kingsvi Date	11e, MD 2 20c. Location - City or	21087 Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygene. Important: If item 27 is marked other it injury or other traumantic event, the Med	- 1	1 X Burial 2 Cremation 3 Removal from State crematory or other place)	oruary	Darkui 11a	Manufand
altin mit. P partme portan ury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	2011	Parkville	
	N	Evans Funeral Chapel 800 Farford Road Pa 23a. Part I. Finite the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	& Cremation & Cremation & Marketine & Mark	on Services-F Jaryland 21234	arkville L
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3760, ificate be g physic s the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 12b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnance of 12 months?	ancv	23d. Date of deliver	y Day Year
b. Box 687 the death certific by the attending I ched for use as the		past 12 months? 4 Pregnant at time of death 5 Other (Specify)			, , , ,
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Division o spital or Attending hours after death. neral Director: After filled in by the func		3 Suicide 6 Could not be determined (Secrify) Only on the Hill Could not be	or Town, Sta	ate) 8800. Wa 1	rat Route Number, City
C Fill both		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and		arkville,	
To the Hos within 24 h To the Fur completely		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.		nd place, and due to th	e cause(s)
Š		29b Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	
		30 Name and address of person who completed cause of death (Item 23a)		. 55,441, 14, 20	
		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, N	MD 21223		
State Registra	~	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

OSME

ORIGINAL

315AM 1102/4/20 Mear

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MYRON T NOAR **FEBRUARY** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funerai 1 XM 2 □ F Months Days Hours Min 06/10/1931 Director 030-22-4957 Usual Besidence of Decedent shov 10a. State 10c. City. Town or Location Director or 28a-f s notified BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 725 MT. WILSON LANE, 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3X Widowed 4 ☐ Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 5+ DIRECTOR OF CREATIVE SERVICES PHARMACEUTICAL Be Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ABRAHAM NOAR ANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. ALTERWOOD LANE, OWINGS MILLS, MD MARK NOAR/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State EAST BRUNSWICK, NJ 4 ☐ Donation 5 ☐ Other (Specify) BETH ABRAHAM CEM. 02/15/2011 . Sig ture of Funeral Service Lice see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final asphyxia Physician/ Drinnerd near disease or condition resulting in death) Medical Due to or as a onsequence of): **Examiner** Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Duri to for as a nonseduence of burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 page 2 After this certificate I funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?

1 Yes Hospital: Other: 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence & Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury NEAT DrownING 1 Accident 5 Pending February 10,2011 1300 P M 1 Tes 28e. Place of Injury - At home farmatives factory office building, etc. (Specify) SWIMMING POOF, Q CBS13786 LIVING + QCIL, TO 24 hours after death. Funeral Director: A 1300 P Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number of Rural Route Number City or Town, State) 735 Hours 10, 156 Ly 4 Homicide determined Baltimore Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) Signatur 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) Type, Print) MD Trimble

AMEND 28E, PER ME 6939 878712 TRT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Rea. No.

2011

3. Time of Death

3:15

9. Birthplace (State or Foreign

WHITE

10d. Inside City Limits

1 Yes 2X No

21208

Approximate Interval Between Onset and Death

Month

Day

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

FR 16

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2011 rear 11:06a M ARTHUR G. PERRY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ST. BALTIMORE N/A APT 1002 205 N. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours OCT Day, Y 1<u>945</u> NEW YORK 65 Director 215-54-5977 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 ☐ No BALTIMORE MARYLAND N/A10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21231 U.S.A. 205 N. WASHINGTON ST., APT 1002 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A llth grade DISABLED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MAYBELL PERRY CHESTER PERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Perry/Ex-Wife 1301 Birchwood Dr., Oxon Hill, Md., 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) KING MEMORIAL PARK 02-07-2011 RANDALLSTOWN, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lize 2. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
I206 W. NORTH AVENUE DEDLUM 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a co resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death been signed by the should be detached 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of deg Completed by 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? M Natural 5 Pending s after death.

I Director: Af
d in by the fu 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of ex-(Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (I em 23a) (Type, Print) umor

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Dennis T. Purcell PM Februar 1228 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 938 1 🔀 M 2 🗆 F Months Days Hours Min. Dec. 14 Country) 414-58-5778 72 **Director** Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore Dundalk MD 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7610 Spruce Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White "natural", Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working il Hygiene. I **other than** " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Repair General Motors 12th Be At Page 1 and 2 should by artment of Health and Mental Hy artment of Health and Mental Hy " " them 27 is marked of " " aratic eve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin H. Purcell Beulah Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Purcell /wife 7610 Spruce Road Dundalk MD 21222 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) SacredHeartofJesus 2/16/11 Baltimore MD 22. Name and Address of Facility . Signature of Foneral Service Licensee 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ 15chemic Cardiomy opall disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Coronary anteny years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transi Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes ည 1 npatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pendina 2 🗌 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 KC Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D41593 2011 maryland 14 my

State Registrar Da Itimore

Pa-Ki

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mp 201

E University

32. Registrar's Signature

J Sloane

6

31. Date filed (Month, Day, Year)

Paskel, Virginia 2/14/11 53Am

			For State Registrar		Maryland	•	artment tificate					Reg. No	Z U 1	Ö	1.438
п	Physicia		1. Decedent's Name <i>(First, Mi</i> Virginia W Pa								2. Date of Dea		y 2011 Yea		Time of Death 5:20a
9	Medic Examin	er	4a. Facility Name (if not institu Oak Crest Villa	age				ville)				. County of D	re	
	Funeral Director		5. Social Security Number 232 26 2199 Usual Residence of Decedent	6. Sex 1 M 2 F X	Age (In yrs. Ias	st birthday) Yrs.	If Under	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Februar	v Year)		Country)	(State or Foreig
	Maryland 28a-f show etified at	Funeral Director	10a. State 10b. Cou	nty Ltimore City	,	Town or Loc Ltimore	cation								nside City Limits
	vith the 23a or 3	eral D	10e. Street and Number 3904 Hamilton	Avenue	·		10f. Zip (ode 2120 6	6			10g. Cit	tizen of What USA	Country?	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ I 3 ☑ Widowed 4 ☐ Divor	ced If Yes, Give Year or Date	es? !□ X No	1	Yes, specif	y Cuban, [XNo	, Mexican, Specify:	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		14. Race - Ai Black, W Specify:		
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d 21	ad withii Hygiene other th	Be Co	12 17. Father's Name (First, Midd	N/A	0.017	Housev	vife	1.	18 Mothe	r'e Name	(First, Middle,		Usekeepi	ng-Ow	n Home
ylano	should be filed within 72 n and Mental Hygiene. 7 is marked other than " raumatic event, the Med	To I	Russell F Whit	mer						ia Day		Margeri	Gurriarie		
Baltimore, Maryland	nd 2 shoul ealth and n 27 is m	1	19a. Informant's Name/Relation Frank Lidinsky								Route Number				
more	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 Burial 2 Cremat 4 Donation 5 Other	ion 3 Removal from Ser (Specify)	toto cei	ace of Dispos metery, crem Land M e	natory or oth	ier place)	ı. Febi		ate 17 2011		ocation - City t imore , N		
Balt	permit. Departr Import any inji		21. Signature of Funeral Servi	ce Lipensee	D	22	assann 7401 B	^⊭dres elair	ral Ho Road	ome In Balti	ic more,Mar	ylan	d 21236		
	Ph_sician/ Medical Examiner	jr.	23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ist only one cause on each Debo Due to (or Alzho	as a conseque	ence of): Disea.		of dying,	, such as c	cardiac or	respiratory arr	rest,		Inte	oroximate rval Between set and Death
09,	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Completed by Physician/Medical Examiner	if any, leading to immediate cause. Eine Unidentifying Cause (Disease or iinjury that initiated events resulting in death) Last	С.	as a conseque										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 🗌 Fetal nt at time of de	death 3	Ectopic pr Other (spe						23d. Date of Month	delivery Day	Year
s, P.O.	res that t signed b	d by P	Part II. Other significant cond	ditions contributing to dea	th but not resul	Iting in the u	nderlying ca	ause give	n in Part I.		23e. Did to		use contribute		use of death?
Records,	he law require te has been si age 2 should	omplete									24a. Was a autop perfo	osy rmed?	prior death	to comple	ndings available
	ician: T certifica rector, p	To Be C	25. Was case referred to medi examiner? 1 Yes 2 No	Hospital:				Other	ce of Deatl		only one)				
n of Vital	ding Phys :h. After this funeral dii		27. Manner of Death 1 Natural 5 ☐ Pe	28a. Date of (Month,	patient 2	R/Outpatien 28b. Time of injury		c. Injury a work?	4 Nu	28	ne 5 Resid			ecify)	
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 ompleted filled in by the funeral director, page 2	Il Certificate:	3 🔲 Suicide 6 🗆 Co		Injury - At hom , etc. (Specify)	ne, farm, stre			00 2 1	_	8f. Location (S City or Tow	Street an n, State	d Number or)	Rural Rou	te Number,
	Hospital 24 hours Funeral eted filled	Medical	(Check 2 Medic	ying Physician: To the bes al Examiner: On the basis ying Nurse Practioner: To	of examination	and/or invest	igation, in m	y opinion	, death oc	curred at t	he time, date a	nd place	e, and due to the	ne cause(s)	and manner sta
•	To the within To the Comple	2	29b. Signature and title of cert	ifier 1	230. Or my I	,oviouge, u	29c.	License r	number	and place		29d. Da	te signed (Mo		Year)
	3		30. Name and address of pers Michealle G Har	on who completed cause			rint)		•	NO	2/234				
	Stat Registra		31. Date filed (Month, Day, Yea FEB 1 6 20	ar) / 32. Reg	istrar's Signatu	ire	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 12:30PM Mary Agnes Pugaczewski 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1331 Pleasant Valley Road Catonsville . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2X F Feb 27, Year 1918 Months Hours Virginia 218-36-8928 92 **Director** Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Catonsville Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 21228 USA 1331 Pleasant Valley Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse State Of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes Easby - Smith Joseph C. Elbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .331 Pleasant Valley Road Catonsville, MD 21228 Jean Sansbury, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 02/16/11 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, <u>Maryland 21228</u> Thomas a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final 4/2heimer Physician/ disease or condition resulting in death) gres Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) anding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the human terminal. Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 Pending worl 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 [] 3 [] Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2011 For person who completed cause of death (Item 23a) (Type, Print) COEIV

State

Registrar

. Date filed (Month, FEB 16

Day Year

2011

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any injury or other traumatic event, the Medical Examiner must be notified at
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit a 30 bit

Funeral Director

Control of the contro	are and mber 6. S 097 Decedent 10b. County Cecil Der Orive d 2 Married Divorced 5. Decedent's Edvinly highest gradury (0-12) irst, Middle, Last, me/Relationship (Ourdy / sition Cremation 3 — Other (Specifical Service Liber diseas, or comfaillure. List only	Prestreet and number Rehab. Sex 7. I M 2 1 F 7. I M 2 1 F 7. I M 2 1 F 7. I M 2 I M 2 M F 7. I M 2 M 2 M 5 F 1 M 2 M 5 M 2 M 5 M 2 M 5 M 2 M 5 M 2 M 5 M 2 M 5 M 2 M 5 M 2 M 5 M 5	Age (In yrs. Is 4 10c. City E11 ent Ever in U.S es? X No es: 0r 5+) 10c. City And ent Ever in U.S est the death	Yrs. Town or Location 16a. Decer (Give life.) COM 19b. Mailin 28 Sace of Dispormetery, creations G.	Elkton If Under 1 Year Months Days Cation 10f. Zip Code 21921 Was Decedent of If If Yes, specify Cub 1 Yes 2 No dent's Usual Occu, kind of work done DO NOT use retire puter An Ing Address (Street L. Johns sition (Name of matory or other pla ifts Regist 2. Name and Address Name and Address L. Name and Address Regist	Hispanic Origin? (Span, Mexican, Puer Specify: pation during most of word) 18. Mother's National August Au	Specify Yes or Noto Rican, etc.) Trking me (First, Middle, Internal Route Number, Interna	Day V 8, 4c. C Vear) 966 Og. Citize U. 16b. Kinc Tec Maiden Si On, D 20c. Loca Hanc	en of What County S.A. Bace - America Black, White, et Black, White, et Cipecify: What of Business/Incompared to the County Business (Incompared to the County Business) County of Death County Business (Incompared to the County Business) Town, State, Ziput E 19808 Station - City or To	aware Od. Inside City Limit: 1 □ Yes 2 ☑ No ntry? can Indian, etc. nite dustry (nknown
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Certifier 1 (Check only 2 one)	Certifying Ph Medical Exam	niner: On the basi	is of examinati	ledge, deatl on and/or in	occurred at the ti vestigation, in my	ime, date and plac opinion, death occ	e, and due to the durred at the time, o	ause(s) a ate and p	and manner as s place, and due to	tated. the cause(s)
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No no no no no no no no no no no no no no	as decedent p the past 12 m	s case referred to medical miner? Yes 2 No Destance of Death Natural 5 Pending investigation determined Suicide 6 Could not be determined Pertifier 1 Certifying Procheck only 2 Medical Example Medical E	as decedent pregnant the past 12 months? Yes 2 No	as decedent pregnant the past 12 months? 23c. if yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown Other significant conditions contributing to death but not result in the past 12 months in the past	as decedent pregnant the past 12 months? Yes 2 No	28c. yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Other significant conditions contributing to death but not resulting in the underlying cause given by Other significant conditions contributing to death but not resulting in the underlying cause given by Other significant conditions contributing to death but not resulting in the underlying cause given by Other significant conditions contributing to death but not resulting in the underlying cause given by Other significant conditions Other significant conditions Other significant conditions Other significant conditions Other significant conditions Other significant conditions Other significant Other significant conditions Other significant Other si	23c. if yes, outcome of pregnancy the past 12 months? Yes 2 No Unknown	23c. flyes, outcome of pregnancy 1	as decedent pregnant the past 12 months? Yes 2 No Unknown	as decedent pregnant the past 12 months? Yes 2 No

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20a-c per fh g912 2-16-11 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Febusar 10:13 1 M 2011 Redd Virginia Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Mary 09/2, ta Genera 1timore M ana 1-14 . Age (In yrs. last birthday) If Under 24 Hrs. 8. Daye of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Min. (Manth, Pay Year) 1 MD (Country) 218-28-7043 79 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 □ No NA Baltimore MD 10e. Street and Number 10f, Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral USA 21211 2095 Rock Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etcAfrican 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? δ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiens. Immortant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates specify:American 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Baltimore County Professor 4+ yrs. Be 17. Father's Name (First, Middle, Last) William 18. Mother's Name (First, Middle, Maiden Surname)
Clara Pettigrew Pettigrew ဂ္ Clara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
201 E. Baltimore Street 15th FI. Baltimore Artie Shaw-Guardian 20a. Method of Disposition 20h Place of Disposition (Name of Mertal of Carachia toryace) 20c. Location - City or Town, State Date Lansdowne, Catonsville, MD +X Burial 2 X Cremation 3 Removal from State 02-15-11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility WylieFuneral Street Baltimore, MD 21217 P 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MATION disease or condition Medical resulting in death) consequence of): Examiner HAMINCYFAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 N 2 **N**No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes 2 1 MInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTMONE SUITE 708 VARGHESE 821 N. Guimu 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Co. 108 Wellham Ave. N.W. Glen Burnie 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖬 F Months (Month, Day, Yea Mary Land Director 214-44-2126 64 946 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Md. A.A. Co. Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 108 Wellham Ave N.W. 21061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No within 72 hours after ģ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 land Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell J. Elnora May Hardy Fesig permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Wellham Ave. N.W. Glen Burnie, Md. 21061 John D. Rice injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 2/12/11 Bayview Crematory 4 Donation 5 Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 masseles en 4001 Ritchie Hgwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law cate has page 2 s autopsy performed Yes 2 certificate 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending Accident Suicide 1 Yes 2 🗌 No Investigation 6 Could not be s after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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State

Box 68760

P.O.

Records,

Division of Vital

and address of person who completed cause of death (Item 23a) (Type

32. Registra

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Rutledge AM 14 2011 2 /Medical 4b. City, Town, or Location of Death 4c. County of Death cility Name (If not institution, give street and number) Examiner Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 25 F Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 Tes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatte event, the Medical Examiner must be notified. Director 1 Hmore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral American Indian Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 6 3. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) - EMPlou 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type Care) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 3 ☐Removal from State 1 Surial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Lice Pd Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line. ng, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit Dabelt that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Jo my Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 400 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Disk 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending F 24 hours after death. Funeral Director; After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide determined 4 Thomicide To the Hospital within 24 hours at To the Funeral C 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW BALTIMORE MD 2/20 St Snite 308

State Registrar 31. Date filed (Month, Day, Year)

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Keider Year Month Donald W 6:45 PM 2.011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 578 Henderson Road Harford Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Min. Hours Month, Day, Year) 10/30/1935 **Director** Yrs 214-34-4325 Jsual Residence of Deceden 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2X No MD Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 578 Henderson Road 21014 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. b 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Fastern Stainless Steel Production Control Manager Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John H. Reider Louisa A. Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t <u> 578 Henderson Road - Bel Air.</u> <u>Patricia E. Reider (wife)</u> Marvland timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State
 XBurial
 2 □ Cremation
 3 □ Removal from State
 Donation 5 🗌 Other (Specify) Air Memorial Gdns 02/18/2011 Bel Air, Maryland Signature of Funeral Service Licensee Bai 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line metastatic undifferentiated sinonaral corringma Immediate Cause (Final Ph sician/ disease or condition resulting in death) yeurs Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of,: Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tailure, renal insufficiency gaston testinel 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available bleed inc 24a. Was an autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🛣 Residence 6 🗌 Other (Specify) 1 ☐ Yes 2 ☒No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Matural 5 Pending M after death

Director: A

I in by the f Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medica Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D39639 2-15-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zimin MD, 22 S. Greene St. Baltimore MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 FEB Registrar

8:50 а.ш. FEBRUARY 13, 2011 ALBERT RITTENHOUSE

			Please Type or Pri State of Management State of Management State Registrar	aryland / Depa		ealth and M	lental Hy	giene	2011	04446
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Albert Ward Rittenhouse		imouto or b		2. Date of Dea			3. Time of Death 8:50 AM
~	Examir		4a. Facility Name (if not institution, give street and number) Stella Maris Hospice 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	4b. City, Town, or L Baltimore If Under 1 Year Months Days		8. Date of Birt	h E	. County of Death Baltimore 9. Birth	nplace (State or Foreign
	Director -f show ifed at	ector	220 36 6226 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town or Local Baltimore	cation	Tiouis IVIIII	(Month, Da March 1	4 19	41 Balt	ntry) Maryland 10d. Inside City Limits 1 □ Yes 2 □ No
	with the Ma 23a or 28a ist be notii	Funeral Director	10e. Street and Number 15930 Irish Avenue	Datasa	10f. Zip Code 21111			10g. Ci	tizen of What Cou	
30. d. III.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 【X)Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Farmed Forces? 1 ☐ Yes 2 ☐ Yes (sive Year or Dates.)	(No	Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	d within 72 hou ygiene. ther than "nat tt, the Medica	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5 N/A	(Give life. D	dent's Usual Occupat kind of work done du O NOT use retired) Employed	ring most of worki		Fue	el Oil Com	
Maryland 2	ould be filed nd Mental H marked ot imatic ever	To B	17. Father's Name (First, Middle, Last) David G Rittenhouse 19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street an	18. Mother's Name Evelyn i	Veal			Code)
EBKUAKT I	ge 1 and 2 sh nt of Health ar :: If item 27 is or other trau		Janet T Rittenhouse (Wife) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	15930 20b. Place of Disponsemetery, crem	D Irish Avenu position (Name of matory or other place)	ue Monl	kton, Mar Date	yland 20c. L	d 21111 ocation - City or	Town, State
Baltimore,	permit. Pa Departmer Important any injury once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service/Dicensee		matory Inc ^{2. Name and Address} Lassahn Fun 7401 Belair	of Facility eral Home	Inc		ltimore,Ma	ry±and
	Pnysician Medical				er the mode of dying,				1 21230	Approximate Interval Between Onset and Death
00	ath certificate be executed attending physician and for use as the burial-transit	lical Examiner	Cause (Disease or iinjury that initiated events c.	a consequence of):		_				
OUSE Box 68760	that the death certificat red by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
ALBERT RITTENHOUSE /ital Records, P.O. Box	v requires that th s been signed by should be detac	by	Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause give	en in Part I.	23e. Did to		1	the cause of death?
ALBERT RITT Vital Records,	i cian: The law recertificate has be rector, page 2 sh	e Completed	25. Was case referred to medical		26 Plac	ce of Death (Check	24a. Was autoj perfo 1 \sum Yes	osv	prior to c	opsy findings available ompletion of cause of
AL Division of Vita	ding Phys h. After this funeral dii	Certificate: To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	ient 2 ER/Outpatier ury ury, Year) 28b. Time of injury ury - At home, farm, str	ont 3 DOA Others f 28c Injury a work? M 1 DOA	4 □ Nursing Ho	me 5 Residence Residence Page 1	now injur	Other (Speci ry occurred	
Divis	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completed filled in by the	Medical Cer	4 Homicide determined 256. Flace of high building, etc. 29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of etc.)	c. (Specify) f my knowledge, death	occured at the time, o	date and place, an	City or Tow	vn, State	nd manner as sta	ted.
5	To the H within 24 To the Fi	Me	29b. Signature and title of certifier 1 1000 CANA) best of my knowledge :	29c. License r	time, date and plan		e resultat		stated.
5 P	Sta Registr IMH 17 Rev 7/2	ar		DULANEY VAL	•	TIMONIUM	, MD 21	093		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan		artment of		and M	1ental Hy	giene	6518	7
			Registrar 1. Decedent's Name (First, Middle	e, Last)		Cer	tificate of	Deam		2. Date of De	Reg. No.	2 11	3. Time of Death
ı	Physicia Medio		Jeannette L	. Riemer						Feb.	14 ^{Day}	2011	3:05 PM
	Examin	er	4a. Facility Name (if not institution Blakehurst Ret		,		4b. City, Town,	or Location WSON	of Death		4c.	County of Death Baltimo	
_	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I		If Under 1 Year	If Under		8. Date of Bir		9. Birth	place (State or Foreign
	Director		045-14-6962 Usual Residence of Decedent	1 □ M 2 🟋 F	- 8	8 Yrs.	Months Days	Hours	Min.	Februa Pa	⁵ 1923	3 Coul	"Connecticu
	land show d at	ţō	10a. State 10b. County		10c. Cit	y, Town or Lo							10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	MD Ba1 10e. Street and Number	timore				son					1 Yes 2 XNo
	with th 23a o sst be		1055 West Jopp	a Road			10f. Zip Code	21204			-	zen of What Cou Ited Sta	•
	death items ner mu	by Funeral	11. Marital Status	12. Was Decede		S. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Or oan, Mexica	rigin? (Spec	cify Yes or No- Rican, etc.)	1	14. Race - Ameri Black, White,	· · · · · · · · · · · · · · · · · · ·
036	s after ral", or Exami		1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Van Cina	2.	1	☐ Yes 2 🔀 N	o Specify	<i>i</i> :		8		ite
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed		nt's Education est grade completed)			ent's Usual Occu		st of workir	na	16b. Kir	nd of Business Ir	ndustry
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	d 2 sho alth an 1 27 is er trau		Corbin Riemer /				g Address <i>(Stree</i> Upper G				-		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from St	l c	emetery cren	sition (Name of natory or other pla	ace)		Date		cation - City or T	
<u>ti</u>	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (S	Specify)	Me		ematory						Maryland
Ba	permit Depar Impor any ir		21. Signature of Funeral Service L	Alyson	к тау	lor 22	99 Frede	rick :	™ Cre Rd.,	mation Baltim	ore,	Marylar	Maryland nd 21228
4	a 5		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that cau only one cause on each	sed the deat line.	h. Do not ente	r the mode of dy	ng, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between
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09	ate be executed ohysician and the burial-transit	edical		d									
	ertifical ding ph		IF FEMALE:	23c. If yes, outcor	me of pregna	incv							4
Box 687	eath certific e attending p d for use as	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Bir 4 Pregnar	th 2 ☐ Feta nt at time of o	al death 3	Ectopic pregnar Other (specify)	ncy			2	3d. Date of deliv Month	rery Day Year
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Division of Vital Records,	w requ	plete	Cercisood	listic syn	- dis	uso,	Dene	nten		24a. Was		24b. Were auto	psy findings available
Rec	sician: The law r certificate has k irector, page 2 s	Com								autor perfo 1 Yes	rmed? 2 No		ompletion of cause of
ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		FD/0	Ott	Place of Dea			10		
of \	I or Attending Physician: after death. Director: After this certific in by the funeral director,	te: To	27. Manner of Death	28a. Date of		28b. Time of injury	28c. Inju	ry at		me 5 L Resid 28d. Describe h		Other (Specif)	()
ion	ttendir death. tor: Af the fu	Certificate:	1 Matural 5 ☐ Pendin 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	gation			M 1	Yes 2					
Divis	al or At s after l Direc d in by		4 Homicide determ		etc. (Specify		et, factory, office		2	28f. Location (S City or Tow		Number or Rura	l Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	edical	29a. Certifier (Check Certifying Medical E	Physician: To the best xaminer: On the basis of	of my knowl	edge, death o	ccured at the tim	e, date and	place, and	d due to the car	use(s) and	manner as state	ed. use(s) and manner stated
	o the l	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To t	the best of my	/ knowledge, d	eath occurred at t 29c. Licens	he time, date	e an d place	e, and due to the	e cause(s)	and manner as si signed (Month,	tated.
			· Will	uly			D	50	130	3	Feb.	wary	15 2011
	4		30, Name and address of person v	CHANG	es 1	N) E	int)	5,0	na	W s	T	12000	N M
	Stat Registra		31. Date filed (Month, Day, Year) FER 16 2011	32. Regis	strar's Sign	are and							
			5 mm - 1	1	- 1 /								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 6:05 A M 2011 JACK Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
POLAND 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 1 🗓 M 2 🗆 F Months Days Hours 06/04/1913 Yrs Director 212-34-5365 Usual Residence of Decedent shov 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2X No MD BALTIMORE BALTIMORE ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 37 STONEHENGE CIRCLE, #7 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er than "natural", the Medical Exa 1 ☐ Yes 2 X No Specify 3√ Widowed 4 □ Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 OWNER WHOLESALE CLOTHING Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DAVID RUBIN PEARL SUSSEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA RUBINSTEIN/STEPDAUGHTER 12 WINDSONG COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BETH JACOB CEMETERY 102/15/2011 FINKSBURG, MD 21. Signature Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) MOSTEON Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed ၉ Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital completed filled in by 24 hours

chionic renal	NSG-FICIENCY			1 Yes 2 No 3 Probably 4	Unknown			
				24a. Was an autopsy prior to completion of death? 1 \(\section \text{ Yes} \) 2 \(\section \text{ No} \) \(1 \) \(\section \text{ Yes} \) 2 \(\section \text{ No} \) \(1 \) \(\section \text{ Yes} \) 2 \(\section \text{ No} \)				
25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)				
1 Yes 2/XNo	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other: 4 \(\sum \) Nursing	ome 5 Residence Other (Specify)				
27. Manner of Death Natural 5 Pending Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	•			
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street and Number or Rural Route Num City or Town, State)	nber,			

Certifier (Check only one) 29b. Signafure

Medical 29a.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

tame and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 6

State

Registrar

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 45 A M to brien 2011 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care ltimore If Unde If Under 24 Hrs. Date of Birth **Funeral** 8. 9. Birthplace (State or Foreign 1 🗆 M 2 🗹 F Min Months Vocah 0 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No More 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral Firm 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Completed 3 ₩idowed 4 Divorced Year or Dates lar 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Seconday (0-12) Elementary College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ter) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. MO 21,225 rma 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Sone, I Service Licensee Facility 22 Name and Address Funeral Home, P. A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ FBROVASCUL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Pregnant at time of death 5 Other (specify) Dav 4 ☐ Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of certifie 15 20 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

BALTIMORE MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0056 201 Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death **Examiner** 4c. County of Death N A If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Hours (Month, Day, 03/17) Director 436 44 0178 78 LA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must hour any once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Odenton 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1208 Odenton Road Apt. 106 21113 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Korean Specify: Completed 3 Ulidowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) conday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry P. Sullivan Annie C. Henly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Sullivan / Wife 1208 Odenton Rd. Apt. 106 Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 02/19/2011 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign we of Juneral Service lace Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery funeral director, page 2 should be detached for in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an

Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. completed filled in by the To the Hospital of within 24 hours a To the Funeral D

State

24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🗆 No Yes 2 N 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 2 No 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Day 11:49 AM Lena Mary Shinaberry Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Laurel Regional Hospita 5 Georg Laure 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Min. Hours 57 6770641953 Maryland 216 70 3126 Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Glen Burnie 1 Yes 2 X No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 U.S.A. 58 Glen Ridge Court Apt. B3 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian , or ! Black. White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Finisher Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Bernard Francis Travers Mary Ester Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7924 Allard Court Apt. 201 Glen Burnie, MD. 21061 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Tammy Yeatman / Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 02/16/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Ph_sician/ Cardi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be deteched for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗆 Yes 2 🗆 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February William C. Sorrentino 6:25 AM Medical 4a. Facility Name (if not institution, give street and number)
Loure Regional Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laure Social Security Number If Under 1 Year If Under 24 Hrs last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 123-26-9307 1 🕅 M 2 🗆 F Months Hours Dec To Tay, Y 1931 Country) New York 79 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Prince George's Laurel 1 Yes 2 X No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 12227 Valerie Lane 20708 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Government Urban Planner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Sorrentino Rosa Attianese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Sorrentino / Son 172 Fleetwood Terrace, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Metro Crematory Inc | 02/15/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a, Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cardio-Pulmonary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Se PSIS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Vear Pregnant at time of death 2 No detached Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Ulcer Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 🗙 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife ebruary 14 D60936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van 0 Regional Laurel Abdul M. Tak, MD HOSPITA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day DZ:15PM ADELE SCHONFIELD Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai HOSPITAL of 3attimore 59/timore N/A 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 - M 2 X F 0672371934 Director 116-32-7754 76 HUNGARY Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2412 BRIARWOOD ROAD 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 🎇 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 ARTIST ARTS & CRAFTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ ALEXANDER PREISCH TERESA LOEWINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE SCHONFIELD/DAUGHTER 1834 DELAWARE STREET, BERKELEY, CA 94703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State HILLTOP SERVICE CORP! 02/14/2011 4 ☐ Donation 5 ☐ Other (Specify) TOWSON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a disease or condition Medical resulting in death) Examiner 1 Week remonhase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last REALIFICATION WE WOULD BY WE DICH EXAMINES Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown for Day signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of coumadin autopsy death? 1 Yes 2 No I ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1
Natural 5 Pending tell while walking 1 Yes 2 No Feb 5,2011 Accident Investigation 1200 AM 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State
Briarwood Sidewalk Rd. Baltimore MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier NPI 121576569 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai 2401 W. Belvedere Blid tosvital Komero 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 09. 2011 6:02 P M SWARTZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SUNRISE ASSISTED LIVING COLUMBIA HOWARD Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours Min 1 □ M 2 🛛 F 02/11/1925 Director 217-12-0409 85 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1XXYes 2 □ No N/A BALTIMORE 10e. Street and Number 10f Zip Code ò 10g. Citizen of What Country? Funeral with items 23a 2902 TERRY DRIVE, APT. D 21209 USA Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: Completed WHITE the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 ADMINISTRATOR SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HYMAN **FAGAN** IDA UROFSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC SWARTZ/SON 3206 FERNDALE STREET, KENSINGTON, MD or other: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/13/2011 ANSHE NEISEN CONGR. BALTIMORE, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 YEARS Immediate Cause (Final Physician/ ALZHEIMER'S DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate baucs. Enter Uniterlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CORONARY ARTERY DISEASE Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED Hospital 1 Yes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) I TV I NG the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56531 FEBRUARY 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRY LI, 8600 SNOWDEN RIVER PKWY., #301, COLUMBIA, MD 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 6 2011 Registrar

			1 - State of Maryland / Department of Health an Certificate of Death	-	giene / Reg. No.	e e e e e e e e e e e e e e e e e e e	14.33
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Karen Mae Schreieck	2. Date of De.	ath 0 6 Day	20 1°1	3. Time of Death 3:24 Рм
	Medic Examin		4a. Facility Name (if not institution, give street and number) 322 S. Parke St., Apt. A Aberdeen		4c. C	County of Death	<u> </u>
	Funeral Director	100	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Bin Min. 9 0 7	th	9. Birthp	lace (State or Foreign
	Aaryland Ba-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Harford Aberdeen			1	0d. Inside City Limits 1 Yes 2 □ No
	with the h	Funeral Di	10e. Street and Number 322 S. Parke St., Apt. A 21001		10g. Citize	en of What Coun	try?
9800	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces No If Yes, specify Cuban, Mexican, Porces No Specify: 1 Yes 2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)		4. Race - Americ Black, White, e pecify: Whit	etc.
Maryland 21215-0036	ithin 72 hou ene. • than "nat • the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) Security Guard	f working		d of Business Industrial	dustry
land 2	e 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than ir other traumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, Rankin			
	d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Dawn Gordon / Daughter 19b. Mailing Address (Street and Number of 1214 E. Sanger St	or Rural Route Numbe	er, City or To delpl	own, State, Zip C nia, PA	19124
Baltimore,	permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		20a. Method of Disposition 1	Date 2/8/2011	∣West	ation - City or To t Chest nsylvar	er,
Balt	permit. Page Department Important: P any injury o		21. Signature fromeral Survice Tarring—Cargo 333 S. Parke	Funeral St, Aber	Home deen	P.A	1001
	Physician/ Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused and the mode of dying, such as caused and the mode of dying, such as caused and the mode of dying, such as caused and the mode of dying, such as caused and the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying and disease or conditions. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ATHEROS SEMLE, S	TAG	EVC	Approximate Interval Between Onset and Death
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\			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUPER NOW PROVINCE MED 35 FO	HORD	ME	Beant	IR, MOZION
	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 6 20 1 Server A. Aparillo				

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		•	For State Registrar	State of Man	-	artment of F tificate of D			leg. No.2	04455
	Physicia Medic		1. Decedent's Name (First, Middle, Last) WALTER	Thom	NEON	,		2. Date of Dear		3. Time of Death
đ	Examir		4a. Facility Name (if not institution, give stree			4b. City, Town, or	Location of Death		4c. County of D	
	Funeral	_	Northwest Hospice 5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	iallstown If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director		216 18 3256 1 XX M	2□F 8	7 Yrs.	Months Days	Hours Min.	11/03,	/1923]	Maryland
	land show dat	ţo	10a. State 10b. County	10	c. City, Town or Loc	cation				10d. Inside City Limits
	e Mary r 28a-1 notifie	Direc	Maryland N/A 10e. Street and Number		Baltim			-		1 X Yes 2 □ No
	with th	Funeral Director	516 Arsan Avenue			10f. Zip Code	1225		10g. Citizen of What U.S.A	*
	death ritems ner mi	Fun	The trainer of the or	Was Decedent Ever Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
036	s after ral", or Exami	Completed by	O D Mideward A D Diversed	1 █XYes 2 ☐ No If Yes, Give Year or Dates. W	VII 1	☐ Yes 2 🔼 No	Specify:		Specify:	White
15-0	'2 hour "natu edical	plet	15. Decedent's Educat (Specify only highest grade co	ion ompleted)	(Give k		ation Juring most of worki	ing I	16b. Kind of Busine	ess industry
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pu	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last)	outhern T	hompson		18. Mother's Name		faiden Surname)	
Maryland	ould b nd Mer mark		19a. Informant's Name/Relationship (Type, F		<u> </u>	n Address (Street a		en Suit	City or Town, State.	Zin Code)
	nd 2 sh ealth ar nn 27 is ier trau		May Thompson / Wif	,	1	Arsan Ave				ryland 21225
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			23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca Immediate Cause (Final	ons that caused the use on to ch line.	death. Do not ente	4				Approximate Interval Between Onset and Death
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x 68	ath certific attending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pr	regnancy	Ectopic pregnancy	<i>V</i>		23d. Date of	delivery
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical (29a. Certifier 1 Certifying Physician	To the best of my	nowledge, death o	ccured at the time,	date and place, and	d due to the caus	se(s) and manner as	stated.
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	2+1		30. Name and address of person who comple	eted cause of death	(Item 23a) (Type, Pr	int)	In BI	215	25 do n	21061
	Stat	е	B1. Date filed (Month, Day, Year) FEB 1 6 2011	32. Registrar's S	ignature	-/04 8		//	-, , , , ,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOSEPH C. THOMPSON FEBRUARY 2011 7:03pMedical 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER TOWN, or Location of Death
TOW SON Examiner 4c. County of Death BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X** X M 2 □ F 216-28-6339 Months (Month, Day, Year) Director MARYLAND Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD. N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 728 E. 41st ST USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify BLACK "natural", 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) filed within College (1-4 or 5+) the LITHOGRAPHY INK MAKER Be Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES THOMPSON GENEVIEVE GOLDSBOROUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 LAWNWOOD CIRCLE GWYNN OAK, MARYLAND 21207 JOANNE KESS(DAUGHTER) 20a. Method of Disposition 1 Burial 2 Crer 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Crem 4 ☐ Donation 5 ☐ other (Specify) KING MEMORIAL PARK 2-17-2011 BALTIMORE, MARYLAND 21. Signature Funeral Service Lightnee HIBNER Name and Address of Facility REDD FUNERAL SERVICE JONAZHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immedia Cause (Final Onset and Death Physician/ astro-inte disease of condition The to (or as Lonsequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or ac a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Sarretts 020 DIC and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe ulmonari ny De tensi 1 Yes 2 No 3 Probably 4 Unknown page 2 should Theumatoi 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marie D2090 Daltin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles hatha m 01 2120 11,6 31. Date filed (Month, Day, Year) State

Registrar

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10 Physician/ Taeko Itoi Tull FEBRUARY 201 10:39pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTE TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🍱 F (Month, Day, Year) Jan. 02, 1917 Months Days Hours Director 212-36-1384 94 Mokohama, Japan Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10b. County death with the Maryland 10c. City. Town or Location Directo Maryland Baltimore County Towson 1 🗆 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road Apt. 409 21286-8405 Japan 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic." 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Japanese Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **02** Teacher of Japanese Language Language Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Sennosuke Itoi Tei Ogura Itoi 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Willis Clayton Tull, Jr 800 Southerly Road Apt. 409 Towson, MD. 21286-8405 20a. Method of Disposition 20b. Place of Disposition (Name of ocation - City or Town, State (Harford County) 1 Burial 2 Cremation 3 Removal from State Example True and Company Company Saturday 4 Donation 5 Other (Specify) Forest Hill, Maryland Cremation Services, Inc. Reb. 12, 2011 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093-2215 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Diretoon Medical resulting in death) Due to (or as a consequence of): Examiner ementia Sequentially list conditions, from the light cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or): burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Discount at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performed' ☐ Yes 2 ☐ No 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 유 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending after death Director: Accident 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Prijaction: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02090 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 Horth 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

ODICINIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ernest William Tyler February \mathbf{p}^{M} 2011 11:45 /Medical 10, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Censis Elder-Care Long Green Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** 1XXM 214 F 86 Yrs Director April 30, 217-16-6822 1924 Usual Residence of Decedent death with the Maryland show. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Mannent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f st
ury or other traumatic event, Ite Medical Examinat must be notified. Director 1 □Yes 2 No Maryland Harford Forest Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1804 Belvue Drive 21050 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X7es 2 □ No 1943 If Yes, Give Year or Dates: 1946 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1943-1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: ğ 1946 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Baseball League College (1-4or 5+) Elementary/Secondary (0-12) Umpire Assistant Sports Entertainment Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ernest Tyler Madelyn M. Mullaney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 Belvue Dr. Forest Hill, Maryland 21050 Mr. Phillip Tyler (Son) 20b. Place of Disposition (Name of Bel Centeler), crematory of other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 15, 20c. Location - City or Town, State Department of Important: If it any injury or conce. Feb. 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee Jeffrey R. Testermen 22. Name and Address of Facility

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility

21. Signature of Funeral Chapel & Cremation Services, Bel - Air

3 Newport Drive, Forest Hill, Maryland 21050

Approximation Services and Address of Facility

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Approximation Services and Add Bel Air, Maryland 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HETEURIOS **Physician** Claren disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 NO director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **□**No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation 24 hours after death, le Funeral Director: A letely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed car se of death (Item 23a) (Type, Print) 21212 mi 31. Date filed (Month, Day, Year) 32 Registra s Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Medical Examiner Month Day February 15, 2011 Betty 0538 hrs Vinson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7403 Kirtley Road Dundalk 5. Social Security Number **Funeral** Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 1954 Foreign South Director Months Hours 250-02-9225 South Country South 1 M 2 X F 56 September 17,1956 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. Maryland Baltimore Dundalk 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7403 Kirtley Road 21224 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes 3 Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify: Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Complet 21215-0036 1 and 2 should be filed within Health and Mental Hygiene. 12 years Machine Operator Berry Plastics other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 5 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Kates permit. Pages 1 and 2 sh Department of Health an Important: If item 27 item 27 Friend 7403 Kirtley Road, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 20c. Location - City or Town, State February 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Bayview Crematory 16, 2011 Baltimore, Maryland Donation 5 Other Specify: 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21 Signature of Funeral Service Licenses **Physician** Approximate Interval lure. List only one cause on each line Between Onset and /Medical Immediate Cause (Final disease a Mixed Drug Intoxication(Alcohol, Oxycodone, Quetiapine) Death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any. leading to immediate Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical AMENDED 23a,27,28a-f per me g914 4-6-11 vt 7,8 per fh g914 4-12-11 vt 23c. If yes, outcome of pregnancy attending physician for use as the burial -**X** UNPENDED X AMENDED IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown signed by the bed be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 No. 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes No After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: the 1 1 Yes 2 X No fd 2-15-11 fd 5:31am unknown Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 X Could not be Suicide determined Homicide residence 7403 Kirtley Rd. Dundalk, Md. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. February 15, 2011 30. Name and address of person who completed cause of death (Item 23a)

Registra DHMH 17 Rev 1/2001

OCME 2006

State

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

FFR

ORIGINAL

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Wrightel Day Year France) 4:40 8. Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Mary land Age (In yrs. last birthday) Funeral 1 MM 2 □ F Yrs Director Jsual Residence of Decedent 28a-f shor 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No More ö 10e. Street and Number 10g. Citizen of What Country? Funeral "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates lac traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ° Elementan /Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 ltv 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licenses Home, P. A. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ conver disease or condition Lung) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) forι in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I page performed? Yes 2 2 No 1 🗌 Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 715RW apara M.D 29d. Date signed (Month, Day, Year) 00057 465 2/12/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - S Ryapaks e MD 2835 S mim N 5 W 21209 Baltnone 5-208 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LYNETT February Day WOMACK 6:31 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BUN SECULRS BALTINODAE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2 🛣 F Months Hours Min 217-66-2847 52 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? be ms 23a must be Funeral 1529 Leslie Street 21217 USA "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status Armed Forces? β 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: American Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Hosp. Cook 12th Grade NA permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Anderson Viola Charles 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin Wheeler, Sr. 1529 Leslie Street Baltimore, MD 21217 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 02-19-11 4 ☐ Donation 5 ☐ Other (Specify) Zion Cem. Lansdowne, MD Wylie Funeral Home P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ CEREBRA2 OEDEMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ENCEPHALOPATHY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 013STRUCTIVE LUNG DISEASE CHRDNIL that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown PIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy SUBSTANCE performed? Yes 2 No A13 USE 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕅 No ျ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c License number D23300 FEISENARY 121 2011 N123, 30N3E2D4R3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000W, BA2TO, ST, BA2TO, MD, 21223

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) FEB 16

32. Jegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 11:56P M Sarah Jean Wright Medical 2011 ebruary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Cherry Lane Nursing Center Laurel Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X**☐ F **Director** 410-42-5421 08/28/1928 South Carolina Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 XYes 2 No PG Glenn Dale MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20769 USA 6206 Guinevere Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: Black and Mental Hygiene. Completed 3 X Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Self 11+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) bef Ethel J. Liddell Clarence Lattimore . Page 1 and 2 should b ment of Health and Mer tant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Wright 14117 Gullivers Trail; Bowie, 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I 1 Burial 2 Cremation 3 Removal from State injury or 2/25/2011 Landover, Maryland 4 Donation 5 Other (Specify) Harmony Mem. Pk. 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Juneral Pervice Licenses Road; Temple Hills, 20748 594 Beech 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown g Unknown P.O. I signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? 2 🔀 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 1 X Natural 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier . License number 29d. Date signed (Month, Day, Year) 6 201

Registrar
DHMH 17 Rev 7/2009

State

20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

gillet he

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28e per doc/8912, 2-25-11 vt. State of Maryland / Bepartment of Health and Mental Hygiene 1 - State Registrar 454 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Day 444 PM 2011 Brenda Marie Woods 10 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SOMOPHIAN HOSPITAL MD BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XX (Month, Day, Year) Days Hours Min. 216-54-0890 60 **Director** MD 22-1950 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 😿 Yes 2 □ No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a o Funeral 4406 Bowley 21206 Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 X Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meonee. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> Teacher yrs Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Wilkens Martha Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15601 Cheswick Lane Upper Marlboro, Gregory Woods-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Pk 2-18-2011 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final UPOSEPSIS HTIW SEPTIC SHOCK Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CKUTE MYOCALDIAL INFARETION HOURS Sequentially list conditions, Examiner cause. Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DUBETES TYPE 2, HYPEDTERSION, HIV, HYPEDUPIDEMIA à No 3 ☐ Probably 4 ☐ Unknown 1 Yes CEREBPOVACCULAR SCCIDENT IN 2001 & 2006 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy PERIPHERAL NASCULAR DISEASE Yes a No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, Hospital 21 No 1 🗆 Yes ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: Natural 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending __ Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined HOME Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. PES 000 2/10/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOLTIMORE, MD SOMTIOGO, M.D. KHIMBELLEY 31. Date filed (Month; Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ FEBRUARY 10, 2011 315 AM M DOROTHY MAE COPELAND WOOD Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner PRINCE GEORGES FORT WASHINGTON NURSING & REHAB FORT WASHINGTON 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 1 □ M 2**XX** Hours VÍRGINIA 1923 Yrs 578-46-3323 87 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified XX Yes 2 No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20037 725 24TH STREET, NORTHWEST Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black. White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify Specify: BLACK XX Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed, (Give kind of work done life. DO NOT use retired) during most of working al Hygiene. 5 other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 11THDOMESTIC WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked ည CARRIE JANE STRATTON JOHN COPELAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau TEMPLE HILLS, MD 20748 2303 FAIRLAWN STREET BERNARD S. WOOD, JR. / SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 02/18/2011 CLINTON, MD 4 Donation 5 Other (Specify) Funding Se Signa ROBERT G. MASON FUNERAL HOME, INC. 1661 GOOD HOPE RD. SE WASHINGTON WASHINGTON, DC 20020 DONALD R. olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Enter the disease, or or heart failure. List o Onset and Death Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any loading to in middle cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consquence of attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 nknown DECUBITUS ULCERS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FEEDING DYSFUNCTION ate has bage 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) : After this funeral 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Director: A 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours of To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or inestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) FEB 16

0 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12017 FT. WASHINGTON ROAD EDGAR V. POTTER, M.D. 32. Registrar's Signature

ORIGINAL

D42955

DHMH 17 Rev 7/2009

FEBRUARY 10, 2011

FT. WASHINGTON, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

			For State Registrar	te of Maryland		tificate of L			Reg. No. 2011	04466
	Physicia		1. Decedent's Name (First, Middle, Last) Jimmie R. Wat	kins				2. Date of Dea Month Feb.	10 2011	3. Time of Death
	Medic Examin	_	4a. Facility Name (if not institution, give street an			4b. City, Town, o	r Location of Deat		4c. County of Deat	th
تحمدي			12 Brenda Lee Co			Esse		1	Baltim	
	Funeral Director		5. Social Security Number 6. Sex 216-38-7165	7. Age (In yrs. las		Months Days	If Under 24 Hrs Hours Min.		y Year) 9.8 Bir 3,1941 Co	thplace (State or Foreign untry) NC
	ind show at	٥	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc	cation				10d. Inside City Limits
	Maryla 28a-f s stified	rect	MD Baltimore		Es	sex				1 ☐ Yes 2 🛣 No
	h the sa or 2 be no	al Di	10e. Street and Number			10f. Zip Code	4 2 2 4		10g. Citizen of What Co	ountry?
	ath wit	Funeral Director	12 Brenda Lee C	Decedent Ever in U.S.	. 13. V		1221 ispanic Origin? (S	pecify Yes or No-	USA 14. Race - Ame	erican Indian.
36	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2 No s, Give or Dates.		Vas Decedent of H Yes, specify Cuba		o Rican, etc.)	Black, Whit	
2-0	hours 'natur dical l	olete	15. Decedent's Education (Specify only highest grade comp			ent's Usual Occup		rkina	16b. Kind of Business	Industry
2	thin 72 ne. than '	Completed	Elementary/Seconday (0-12) Coll-	ege (1-4 or 5+)	life. DO	O NOT use retired)	_	, and a second	Potts &	Callahan
Maryland 21215-0036	filed wit tal Hygie od other event, th	Be	10th 17. Father's Name (First, Middle, Last)		11	uck Dri		me (First, Middle,	Maiden Surname)	041.411411
/Jan	d be fil dental irked tic ev	욘	Pete Watkins				Lucy	7 Mae G	oodey	
¶ar\	sh is au		19a. Informant's Name/Relationship (Type, Print		1				r, City or Town, State, Zi	
Ġ.	and He He		Gloria Rossman /	friend		Brenda sition (Name of	Lee Co	ourt Ba	1to. MD 2 20c. Location - City or	
nor	Page 1 nent of ant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State C6	emetery, cren	cremat		11/11	Baltimo	
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Signat re of Funeral Strvice Licensee			. Name and Addre	4.50		e Ave. Ba	
m	De la la la la la la la la la la la la la		Danue RV	eng			<u>ly Fune</u>	eral Ho	me of Ess	ex 21221
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	on each line.						Approximate Interval Between Onset and Death
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3760			IF FEMALE:	-						
80 ×	aath certifica attending p	Physician/M	23b. Was decedent pregnant 23c. If ye	s, outcome of pregnar Live Birth 2 Fetal	death 3		су		23d. Date of de	elivery Day Year
8	the at	ıysic	1 Ves 2 No 4 -	Pregnant at time of de Unknown	eath 5∟	Other (specify) _			World	Day 10ai
0	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing	g to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ds,	quires en sign			***				1/1	Yes 2 No 3 F	Probably 4 Unknown
COL	law rec las be	Completed						24a. Was auto	psy prior to	utopsy findings available completion of cause of
Be	: The licate h	Con						1 L Yes	ormed? death? 2 X No 1 ☐ Ye	s 2 No
ltal	sician certif lirector	o Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) No	1 Inpatient 2 I	EP/Outpatier	Oth	er:		dence 6 🗆 Other (Spec	nifu)
_	g Phy er this neral d	te: To	27. Manner of Death 28a		28b. Time of injury		y at	7	now injury occurred	Sity)
ion	tendin leath. or: Aft the fur	ifica	1. Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 No			
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: "ifer this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use an	Certificate:	4 Homicide determined	Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (City or Tov	Street and Number or Ru vn, State)	ıral Route Number,
_	Hospii 24 hour Funera ted fills	Medical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the control of the contr	he basis of examination	and/or invest	tigation, in my opini	on, death occurred	at the time, date a	and place, and due to the	cause(s) and manner stated.
	ithin 2 the l	Me	only one) 3 Certifying Nurse Practi 29b. Signature and title of certifier					1		
	F≥Fŏ		· MRC			D31	008		Feb. 11,	2011
	5		30. Name and address of person who complete	d cause of death (Item	23a) (Type, F	Print)		20 7	Feb. 11,	1 0 0 0 0 0
	6		David B Peicher 31. Date filed (Month, Day, Year)	tung 91	US /1	Anklinsq. 1	Dr 5+20	7 136	Itmore u	mn 21857
	Sta Begistr		31. Date filed (Month, Day, Year)	32. Hegistrar's Signati	ure park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 12^y 2014 Harry Thomas Walker, Jr. 7:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Ellicott City **Heartlands** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 2/24/1944 212-48-9170 IlTimois 66 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State by Funeral Director notified 1 Yes 2 ☐ No 28a-f Maryland Baltimore Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö pe ms 23a must be 21210 U.S.A. 1021 Winding Way Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
White 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify: "natural" Completed 3X Widowed 4 □ Divorced Year or Dates. than "natura the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) uth and Mental Hygiene. 27 is marked other than r traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Admistrator Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Nancy Childs Harry Thomas Walker, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4705 Shelley Lane Ellicott City, Maryland 21043 David Childs Walker / Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place Dulaney Valley Mem 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2/18/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson_Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Immediate Cause (Final Physician/ proluvisore disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 1 Yes 2 No 9 Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s performed? Yes 2 2 00 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation after death

Director: / 6 Could not be Medical

Box 68760 P.O. Division of Vital Records, within 24 hours a

To the Funeral D

completed filled i

Baltimore, Maryland 21215-0036

4 🗌 Homicid	e determined	building, etc. (Specify)	actory, office		own, State)
29a. Certifier (Check only one)	2 Medical Examine	ian: To the best of my knowledge, death occur r: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	at the time, date	and place, and due to the cause(s) and manner stated.
29b. Signature ar	nd title of certifier	101 10	29c. License number	~>	29d. Date signed (Month, Day, Year)

State Registrar

To the I within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 8:15P 2011 Eleanor Mary Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore 3625 Rockberry Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XX 01*9227*1925 Mary Tand 220-12-7955 86 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 XXNo Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral 9581 Shirewood Court 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 21 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Taylor Julia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3625 Rockberry Road Baltimore, Maryland 21234 Judith F. Hall DTR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem Gardens 02/18/2011 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State Timonium, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funera 6500 York Road Baltimore, Maryland 21212 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease or complic shock, or heart failure. Itist only one Interval Between Onset and Death Immediate Cause (Final *ena Physician/ thees 10813 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown Ectopic pregnancy in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Dav Pregnant at time of death To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify 2 No ၉ ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manne 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the vithin 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8048 mpleted cause of death (Item 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician DD1 404 HILLAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 06–21–1976 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 217-33-4565 Wash. DC 34 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No MD PG Landover Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1115 Ivy Club Ln. #844 20785 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. SpecifyBlack à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Radio Personality WKYS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H Ivory Walker Sr. Overton Doris မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Doris Walker/Mother 1115 Ivy Club Ln. #844 Landover, MD 20785 permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 02-14-2011 Clinton, MD 4 Donation 5 Other (Specify) 21. San ature of Juneral Service Licensee 22. Name and Address of FacilitRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 tomoso 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown the Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>م</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has The 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 🗌 No 2 ER/Outpatient 3 🗌 DOA 1 / Inpatient ျ this completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Mapner of Death 28c. Injury at Work? Certification: If or Attending P after death. Director: After t (Month, Day Injury Natural 5 Pending investigation 1 ☐ Natura. 2 ☐ Accident 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the

State Registrar

'harles 31. Date filed (Month, Day, Year) FEB 1 6 2011

29b. Signature and title of certifier

Kson 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

parke

29c. License number

amend #19ach Per FH G912 2716/2011 JH. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2011 10:15am G. Yeager, Jr. Jesse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 92 Oleary Lane Port Deposit Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours (Month, Day, Country) 1918 Pennsylvania 92 **Director** May 176-18-1370 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 1 X Yes 2 ☐ No Maryland Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 27 Gunnison Dr 21001 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify Specify: White Completed 3 ₩ Widowed 4 □ Divorced intal Hygiene. ked other than "natura c event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service US Government 12 Page 1 and 2 should be filed witinent of Health and Mental Hygien ant: If item 27 is marked other it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Iva Kugler Jesse G. Yeager, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Aberdeen,Md 21001 Richard Yeager/son 27 Günnison Drive Baltimore. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ferris & Company 2/16/2011 West Chester. PA ^{22. Name and Address of Facility} Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Censes 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ a metastanic Cancer of unknown primary disease or condition resulting in death) 6 munths Medica Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Yes g Unknown g Unknown Hospital or Attending Physician: The law requires that the ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be disease Records, ortend 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA 000048050 Result C thals 2/15/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), #400 Aberdeen MD 21001 rashant Shukla 15 31. Date filed (Month, Day, Year) FEB 16 2. Registrar's Signature State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Margaret Maxine Albright 2011 7:09 p Medical Januar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4347 Sycamore Drive Carroll Hampstead . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Birthplace (State or Foreign Funeral Months Hours Country) 1 M 2 K 170-26-3337 99 **Director** 3/30/1911 PA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Carroll 1 √ Yes 2 □ No MD. Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō with 1 23aFuneral 4347 Sycamore Drive 21074 USA items ? 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 9 þ 1 Never Married 2 Married 2 **X** No Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", If Yes. Give Specify: white Completed 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales department manager Montgomery Ward be filed \ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Ambrose Uber Pearl Gent t. Page 1 and 2 should be rtment of Health and Men traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Albright, son 4347 Sycamore Drive, Hampstead, Md. 21074 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation 1/31/2011 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home Lemmer 934 S. Main Street. Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.
ediate Cause (Final ase or condition Interval Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami Physician: The law requires that the death certificate be executed sician and burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown the 9 🗍 Unknown P.O. I ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy Yes 2 No 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 1 Yes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: or Attending work? injury 1 Natural 5 Pending death. 2 🗌 No To the Hospital or Attendi within 24 hours a er decth To the Funeral Director: A completed filled by the fi Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarah J Fra Hali KID 4231 Nov Howcoads Trail Hampstead 6

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Julius APT January 31 2011 3.10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Renaissance Gardens Prince Georges . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) 1 **X** M 2 □ F Months Hours Min. Ap(Menth, Day, Year) 924 192-16-8807 86 Director New Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Silver Spring 1 ☐ Yes 2 🂢 No Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3160 Gracefield Road 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Was Deceden. __ Armed Forces? 1 ☐ Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 况 No Specify: Specify: white Completed 3 X Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Journalist/Editor/Writer Newspapers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Dubin မ Solomon Apt should be 19a. Informant's Name/Relationship (Type, Print)
Roslyn Apt Johnson, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 17505 Princess Anne Drive, Olney, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🖔 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Har Jehuda Cemetery 02/03/2011 Upper Darby, PA . Signature of Filnera Service License T&reninskyssHebwew Funeral Home 20012 254 Carroll St., NW. Washington, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Year shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Leukemia Medical Due to (or as a consequence of): Examiner Alzheimer's Disease Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) by the attending physician and section of the attending physician and section is a section of the purial-transit 1 Month Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Acute Respiratory Failure Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant
Unknown Pregnant at time of death 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page performed? 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕅 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16112633 30. Name and address of person who completed cause of death (Jem 28a) (Type, Print) 3110 Grace∮ield Road, Silver Spring, MD 20904 Julaine Harding 31. Date filed (Month, Day, Year) 3. Registrar's Signature State

Registrar

FEB 01

11-00842	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Gabriella Audrey /		14.73
Physician Medical Examine	1 Decedent's Name (First, Middle, Last) Or CORICIG AUDREY ADAMS 2 Date of Death Month Day January 30, 2011 1	ime of Death 1029 hrs
	4a. Facility Name (if not institution, give street and number) Prince Goerges Hospital 4b. City, Town, or Location of Death Cheverly 4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthpla Foreign Valual Residence of Decedent	Ce (State or
Maryland 28s-f show any d at once.	10a. State 10b. County 10c. City, Town or Location 10d	I. Inside City Limits Yes 2 No
r death with the Maryland or items 23a or 28a-f sh	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745	
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16 n 72 hour nan "natu ical Exan		try
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked ruther than injury or other traumatic event, the Medica.	I James Thomas Adams III Taka Jeanene Kobe	ertson
and 2 should and 2 should tealth and Me tem 27 is mai traumatic ev	1 GRG Robert 50n/Mother 2234 Alice Avenue Oxon/HII MD 207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town	n, State
Baltimore, permit. Pages 1 ar Department of Ho, Impurtant: If ite	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signifure of Funeral Service Licensee 22. Name and Address of Facility Niseman Funeral Service Licensee	
m ឧក្សាធា Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart April 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart April 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	oproximate Interval
xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	etween Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be execut synthin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and prompletely filled in by the funeral director, page 2 should be detached for use as the burial - trained in a function of the funeral director.	#15-16b perFH_C912,2/16/2011, WS IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Year
i, P.O. Bo; ires that the deat signed by the at be detached for	1 Yes 2 ✓ No 3 Probably	
Division of Vital Records, talor Attending Physician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be artification. To Be Completed.	24a. Was an autopsy prior to complete the complete that the compl	y findings available letion of cause of 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical 26. Place of Death (Check only one) examiner? [Hospital:	
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Division o to the Hospital or Attending within 24 hours after death. To the Funeral Director: After scompletely filled in by the funeral Certification:	29a Centiler	
To the H within 24 To the Fu gompletel	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
3	MM () January 31, 2011	lay, Year)
Ex	30. Mame and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year FEB 0 1

Donna M. Vincenti, MD

30. Name and address of person who completed cause of death (Item 23a)

OCME

Registrar's Signature

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ^{Day} 2011 William Joseph Boteler Jan. 29. 6:35 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring P.G. 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1919 1 🗷 M 2 🗆 F Months Days Hours Feb. 24, Washington, DC **Director** 578-10-2013 91 Usual Residence of Decedent 28a-f show 10a. State with the Maryland Ħ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f st edical Examiner must be notified 1 🗌 Yes 2 🖺 No MD Silver Spring Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3156 Gracefield Road, Apt. 403 20904 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ timore, Maryland 21215-0036 White 1 Yes 2 XNo Specify 3 Widowed 4 Divorced Completed Year or Dates WW-II the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 3 Federal Government Printer Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of မ Michael Harmon Boteler Mary Ann Dore traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Aportant: If item 27 is any injury or other trau Donald J. Boteler/Son 656 Tewkesbery Lane, Severna Park, MD 21146 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Feb. 2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Signature of Funeral Service Licenses ouce 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Dementia mo. Medical resulting in death) Due to (or as a consequence of): Examiner Status Post Cerebrovascular Accident 1 yr. Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying To the heaptral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events Coronary Artery Disease 2 yrs. tran Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 No as been signed by the a 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 page 2 \square No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 🗶 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1X Natural 5 Pending М 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Sompleted filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2ga Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 11263 30. Name and address of person who completed cause of death (Item 26a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Julaine Harding, CRNP

31. Date filed (Month, Day, Year

FEB

32 Registrar's Signature

3110 Gradefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Frederick		1- For State	State	of Maryla	•	partmei ertificat			id Men	tal Hy		.	2011	14410
Physici	an/	Registrar 1. Decedent's Name (Firs	t, Middle,Last)		-	-			2	. Date of De			3. Time of Death
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I.		4a. Facility Name (if not in Everly Road Nea			mber)			. City, Town, o Accident	r Location o	of Death			c. County of Dea Garrett	ath
Funeral		5. Social Security Number			7. Age (In yrs	s. last birthd		If Under 1 Yea	ar If Unde	er 24Hrs.	8. Date of B			Birthplace (State or
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with th s 23a	삘	11. Marital Status	I Ru.	12. Was Dec	edent Ever in	U.S. 1	3. Was	Decedent of Hi	spanic Orig	gin? (Spec	cify Yes or N			erican Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ustural", or items 23s or 28s-f show injury or other traumatie event, the Medical Examiner must be notified at once.	리	19a. Informant's Name/Re Patricia A.						ddress (Stred Iarman I					city or Town, Sta 21520	ate, Zip Code)
and 2 and 2 lealth treup	H	20a. Method of Disposition			201	b. Place of [Dispositio	on (Name of ce			Date		Location - City	or Town, State
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E. F. G.		W. Lyun,		nau	/		P.C	Box	275,	Grant	sville	e, N	MD 2153	
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D. B. t the de by the ached f	Phy	Part II. Other significant	conditions	contributing to		t resulting in	the und	derlying cause	given in Pa	art I.	23e. Did t	obacco	use contribute	to the cause of death?
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of Vi ing Physi After this	၉	1 Yes 2 N		ospital: 1 Ir	npatient 2	ER/Outp 28b. Tim			Other ₄	Nursing I	-		ence 6 🗹 Oth	ier: Scene
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ivisior or Attendather death Director:	ficat	2 ✓ Accident 3 Suicide 6	Investigatio Could not b	28e Place		1836 h		factory, office t	ouilding, et	c. 28			and Number or F	Rural Route Number, City
DIVIS Popital or A hours after necal Direct y filled in b	Certification:	4 Homicide	determined		Woods					Ev	or Town, serly Road	State) Near V	Veaver Road,	Accident , MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate thin the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the by	Medical	(Olicon only	ai Examiner:	On the basis o	f examination	_							nd manner as st ace, and due to	
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4	AV	30. Name and address of p		ompleted caus sistant Med			10 VA/	Baltimoro S	Street P	altimoro	MD 212	23		
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DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20/1 Charles 3: 10 PM Rodnev Brenner JANUACT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ARUNDE # BURNie Anne Baltimore Washington Mescal Glen 1 Year If Under 24 Hrs.
Days Hours Min 8. Date of Birth (Month, Day, Year) Dec 12 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 📉 M 2 🗆 F 84 Months Director 220-14-6207 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Anne Arundel Severna Park 1 🗌 Yes 2 💢 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 600 McKinsey Park Drive, Apt. 202 21146 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc 1 X Yes 2 No 1944—
If Yes, Give þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced Completed 1946 Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore Gas and Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electric Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hilda Burkhardt Charles F. Brenner permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Brenner / Wife 600 McKinsey Park Drive, Apt. 202 Severna Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Meadowridge Memorial
Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Februarv Elkridge, MD 2011 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Other (specify) Year 4 Pregnant a 9 Unknown Pregnant at time of death 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy After this certificate has Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မှ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniurv work? Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Garding Turne Fractioner. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Garding Turne Fractioner. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Garding Turne Fractioner. 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Henry Francis MD 301 Hospital Drive, Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

DHMH 17 Rev 7/2009

Registrar

FEB 0 1 2011

CHARILS

Brewer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Myrtle M. Bush January 30, 2011 6:14 a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 1 M 2 St F 99 220-76-1135 Yrs. Director May 13. 1911 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location
Westminster with the Maryland items 23a or 28a-f sho ler must be notified at 10d. Inside City Limits Director MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21157 45 Washington Road filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 🗌 Yes 2 😾 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: white Specify. 3 ★Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F t. Page 1 and 2 should be file trent of Health and Mental rtant: If item 27 is marked o ijury or other traumatic ew ဂ္ဂ Winifred P. Houck Herbert B. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2839 Lawndale Road, Finksburg, Md. 21048 Bonnie B. Gibbons, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 2/3/2011 Hampstead, Md. Hampstead Cemetery 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility M01072 Eline Funeral Home S. Main Street, Hampstead, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

day Immediate Cause (Final Physician/ pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, second to minimize cause. Enter Underlying Cause (Disease or iinjury Examine bue to for as a consequence on sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Yea Pregnant at time of death Yes 2 X No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, diabetes mellitus type 2 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: 유 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17040 January 31, 2011 me 2700 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 215 Washington Heights Medical Center Howard G. Lanham,

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year,

FEB 0 2

32. Registrar's Signature

Westminster, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Georgia Baum 0158 2011 Medical Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Peninsula Re gional Medient Cente VICANILO If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 511-20-7991 1 □ M 2 **X** F Min Month 83 **Director** 08/17/192 Kansas Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location with the Maryland 10d, Inside City Limits Director must be notified 1 🗌 Yes 2 🔀 No Maryland Somerset Princess Anne 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 28347 Mt. 21853 Vernon Road USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: white "natural" Completed 3 XWidowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) rug hooking instructor desian and Mental Hygier is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George Saunders Daisey L. (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 28347 Mt. Vernon Rd., Princess Anne, MD 21853 George Baum/son 27 Department of Health Important: If item 2; any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/31/2011 Salisbury Crematory Salisbury, MD Signature of Funeral Service License ²²Holloway funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Septer shock disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as a consequence of burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical the SB IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy ate has been signed by the atte page 2 should be detached for i in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 🗌 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. ineral Director: After 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be the 1 Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined To the Hospital within 24 hours a To the Funeral I completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury Md. 2180 OHRA MD State FEB 01

Registrar DHMH 17 Rev 7/2009

Box 68760 P.O. Records, **Division of Vital**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ゴイル Year Lawrence Winfred Burroughs 2016 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death md. comico 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Year, **Director** 214-03-9541 92 1-28-1918 Washington D.C. Usual Residence of Decedent Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 200 Civic Avenue 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1943 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced 1946 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 10 Mechanic Auto Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GIIV Burroughs Nellie Rhine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Hudson - Daughter 3964 Five Friars Road, Salisbury, Maryland 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 1-30-2011 | Gore, Virginia Fairview Cemetery permit. Signature of Funeral Service Lice 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland 21804 Main Street. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one can ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ause on each line. Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year ☐ Pregnant ☐ Unknown Other (specify) Pregnant at time of death the 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Jas autopsy certificate Yes 2 director, 25. Was case referred to medical examiner?

1 Yes 2 1 10 Be 26. Place of Death (Check only one) Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Watural injury 5 Pending ☐ Accident Director; / Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 [only one) 29b. Signature and title of certifier ပ္ 29d. Date signed (Month, Dav. Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Elizabeth Cichocki 5:00 AM2011 Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Larkin Chase Nursing Center 5. Social Security Number 8. Date of Birth (Month, Day, Yea April 13. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Director 579-20-4137 Yrs 87 1923 Washington, Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a Maryland 1 Yes 2 X No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15005 Health Center Drive 20715 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force: Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 🛮 Widowed 4 🗆 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Perpetual Bank the 12 Computer Programmer of Health and Mental Hygie fitem 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilbur Woodford May, Sr. Ellen Elizabeth Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jeane Halle / Daughter 286 Holiday Way, Oceanside, CA 92057 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State o <u>I</u> Page 1 cemetery, crematory or other place)
Maryland National
Memorial Park ò 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: It any injury or 2/4/2011 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service bicensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Cardiac Arrhythmia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or se a consequence or). sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 9 Unknown the detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ò pe Records, 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? certificate Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DCA 4 X Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one P 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D43351 2/2/2011

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Day, Year)

DW3

Ikechi Frederick Okwara, 12200 Annapolis Road, Suite #316, Glen Dale, MD 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Jan 26, Regina Ann Camp 2011 10:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Nursing Home Adelphi Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2x F Months Davs Hours Min. (Month, Day, Year) Omana, Director 507-16-0793 89 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1X Yes 2 No MD Prince George's Adelphi 5 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 3210 Powder Mill Road 20783 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ٥ 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Duncan D. O'Leary Margaret A. Elsasser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia B. Minot - daughter 5477 Harris Farm Lane, Clarksville, MD 21029 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite cometery, crematory or other place)

Gate of Heaven Cemetery 1/31/2011 1 K Burial 2 Cremation 3 Removal from State Silver Spring, MD injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lie 4739 Baltimore Ave. 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a, 1411. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury Examin Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Month Dav Year 4 Pregnant : 9 Unknown Pregnant at time of death ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed } 23e. Did tobacco use contribute to the cause of death? Completed by Depression, Osteoarthritis, Hypertension, cate has been siç ; page 2 should b 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Seizure Disorder certificate has autopsy performed? Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c, License number 29d. Date signed (Month, Day, Year) D55559 January 28, 2011 MD

Registrar DHMH 17 Rev 7/2009

State

egistrar's Signature

Greenway Center Dr., #312, Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525

Thomas Maslen

FEB 0 2 2011

31. Date filed (Month, Day, Year)

			Flease	type of Fill				-	_	1
			Ear	State of Ma	aryland / Depa	artment of F	lealth and M	lental Hyg	jiene , ,	41103
			1 State		Cel	rtificate of	Death		leg. No.	04400
		-	Registrar			- timodio or	Douth			3. Time of Death
	Dharist	7	1. Decedent's Name (First, Middle, La	st)				Date of Dea Month	itn Day Yea	
	Physici		Lamont D	ushun	Car	ter		1	26201	1 8:51p M
المنتا	/Medic		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death		4c. County of D	eath
E.	Examir	er		·		D - 1				a
			12125 Quadrille			Bowie		La D ((D) II	Prince	
100	Funeral		5. Social Security Number 6. 5	Sex 7. Age 12X M 2 □ F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		328-66-8795	IADA IW ZLIF	38 Yrs.			2/24/	72 Ch	icago Ill.
	70		Usual Residence of Decedent							
	lan ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Aary ed a	ъ,	Annual and Draings	Coomer	Davida					1 XYes 2 No
	he N	Funeral Director	MarylandPrince	George	Bowie	1406 75 0 - 1-			10g. Citizen of What	Country?
	en en	ä	10e. Street and Number			10f. Zip Code			rog. Offizer of what	Country:
	h w 23a st b	a	12125 Quadril	le Lane		20	720		USA	
	ms.	je	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,
	iter	.5	1 ☐ Never Married 🏂 Married	Armed Forces?	do l	If Yes, specify Cub	an, Mexican, Puerto	Hican, etc.)	Black, W	/hite, etc.
36	s af	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	1
8	iour E E	d L			1 12 5					lack
5	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ete	15. Decedent's E (Specify only highest gra	ducation a <i>de completed)</i>	16a. Deced	dent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kind of Busine	ss/industry
7	Me an a	호	Elementary/Secondary (0-12)	College (1-4or 5	+) life. I	DO NOT use retire	d)			
21215-0036	r withii jene. r than the M	Completed	12	0 (rts A	gent		Self-Em	ploved
	filed Hygi ther		17. Father's Name (First, Middle, Last	')			18. Mother's Name	e (First, Middle,	Maiden Surname)	
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Maryland	2 should be filed and Mental Hygi is marked other aumatic event, t	2	Johnnie			inson	Joyce			<u>arter</u>
ā	2 sh and is m		19a. Informant's Name/Relationship ((Type. Print) Wif	e 19b. Mailir	ng Address (Street	and Number or Rur	al Route Numbe	er, City or Town, Stat	e, Zip Code)
Σ	and 2 ealth n 27 i		Charnise Calhou	n Carter	12125	Quadri	lle Land	- Bowie	MD 207	20
a)	1 and 2 Health em 27		20a. Method of Disposition	our our	20b. Place of Dispo cemetery, cree	sition (Name of	220 100	Date	20c. Location - City	or Town, State
ō	Pages nent of I nrt: If its iry or o		1 Burial 2 ☐ Cremation 3 ☐				1			
Ξ.	Pa ant: ury		4 ☐ Donation 5 ☐ Other (Special	fy)	Resurre	ction C	em 2/4,	/11 (Clinton,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ODGE.		21. Signature of Funeral Service Lice	nsee	22	2. Name and Addre	ess of Facility			
m	e a E e		Physical C	1000	A	dams Fi	neral Ho	ome Pa	. Aduasco	MD 20608
			23a Part1 Enter the disease, or com	onlications that caused	the death. Do not ent	er the mode of dvi	no, such as cardiac	or respiratory ar	rest.	Approximate Interval Between
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	ne. 0 .			,	,	Interval Between Onset and Death
A STATE	Physician		Immediate Cause (Final disease or condition	. (0)	edeac	ARK	est			
خدر	/Medical		resulting in death)	Due to (or as	a consequence of):	,,			A	
	Examiner			Com	20 Au	renci a	, mal	witi	lion	
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as:	a consequence of):	wwwc	1 11100	race		
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	nd Iran	аш	that initiated events resulting in death) Last	c. ne	rasvau	c gei	revalu	Re CI	oucs	
o,	exe an a rial-i		resulting in death) Last	Due to (or as	a consequence of):	O_1	0			
200	sicie bu	cal		Park	otio ex	oud	Couce	6		
89	icate phy s the	ğ		1	8		4.0			
×	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medi	IF FEMALE:	OCO Muse subseme						
Вох	th c tend	an/	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐Live birth		Ectopic pregnanc	ev.		23d. Date of Month	Day Year
	dea e at id fo	:	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at	time of death 5	Other (specify) _			Worth	Day Teal
O	the d	λ	9 ☐ Unknown	9∐Unknown						
σ.	requires that the de een signed by the a nould be detached		Part II. Other significant conditions	contributing to death be	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribut	te to the cause of death?
5,	res ign	by	Alm					101	/es 2 X No 3□	Probably 4 Unknown
5	w require been si should b	ed	NO						763 2/10 0	
ပ္ပ	> 9 5	et						24a. Was	an 24b. Wer	e autopsy findings available
æ	The lav	ᆵ						autop perfo	rmed? prior	
or Vital Record	iclan: Th certificate ector, pag	Completed						1□ Yes	rmed? deat 2 No 1 □	Yes 2□No
/it:	ctor.	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	ne)	
1	Physiclan: this certificral director,	To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatier	nt 3 DOA Oth	her: 4 ☐ Nursing Ho	ome 5 Resid	dence 6 Other (Specify)
			27. Manner of Death	28a. Date of Inju		f 28c. Inju	ıry at	28d. Describe I	now injury occurred	
Du	ding 1 h. After funer	ioi	1 Natural 5 ☐ Pending investigatio	(Month, Day	y Year) Injury		rk?]Yes 2 X No			
S	death ctor:	cai	2 Accident investigation 3 Suicide 6 Could not be		unu - At home form -t-			20f Location "	Ptroot and Number -	r Pural Pouto Number
Division	ter c lirec	III.	4 ☐ Homicide determined		ury - At home, farm, sti c. <i>(Specify)</i>	eet, lactory, office		City or Tov		r Rural Route Number,
	spital or Attending rours after death. neral Director: After filled in by the fune	Certification:								
	spi oul	<u>=</u>	29a. Certifier 1 ☐ Certifying P	hysician: To the best	of my knowledge, deat	h occurred at the t	ime, date and place	and due to the	cause(s) and manne	er as stated.

nber or Rural Route Number, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1425K3heet NWWDC2005

2810

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MINES S. SAKILIBA MD 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January SHELBY COMPTON 20 Î Î J. 27°, 5:38 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours July 3, 1948 Kentucky 235-76-7436 62 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Montgomery Gaithersburg 1 X Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 60 State Court 20877 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Uidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Coleman Sally Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie D. Compton (Husband) 60 State Court Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Date 31. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. Alexandria, VA 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licer tus M01116 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death cardiac Ph sician/ arres disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner infavction myocardia acute Sequentially list conditions if any, leading to influentate cause. Enter Underlying Cause (Disease or iinjury the attending physician and the for use as the burial-tr msit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ils certificate has I director, page 2 s autopsy Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this s ar er death.
I Director: After this diby the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours at To the Funeral Discompleted filled in Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) most MD 62580 January 27,2011 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who MD, ago I medial center Drive, Rockville, Maryland 20860 hurosh Nancy 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Leo G. Coddington January 7:20 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Garrett Grantsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day 9. Birthplace (State or Foreign 1 XM 2 F Maryland J<u>an.</u> Director 219-14-5140 90 1920 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 28a-f 1 🗌 Yes 2 🔀 No MD Garrett Oakland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 984 Pysell Crosscut Rd. 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or <u>^</u> 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White WW2 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Electric Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Earl Coddington Vesta Beeghly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Robert A. Coddington/Son 984 Pysell Crosscut Rd., Oakland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Addison Cemetery Feb. 1, 2011 Addison, PA 4 Donation 5 Other (Specify) Signature of Furieral Service Lio 22. Name and Address of Facility Newman Funeral Homes, P.A. Elmoae P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau-Immediate Cause (Final Onset and Death Physician/ peraton disease or condition resulting in death) Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of, attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? 1 Yes 2 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.0. Records, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director; Division of Vital To the Hospital or Attending

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissel, 124 Miller St., Grantsville, MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JAN31

0034231

29d. Date signed (Month, Day, Year)

January 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				1- For Amend Item Registrar	State o	f Ma ne, g	ryland 913,0	/ Depa 3/04/	rtment o 2011dh tilicate	f He	alth a eath	ind M	lental Hy	/giene			-	36
		Physici	an	Decedent's Name (First, Middle, Last)									Date of Death Month Day			Year	3. Time of	Death
		/Medic		BARBARA MAI							_		JANUAR	XY 3	1	2011	19:54	PM
		Examir	ier	4a. Facility Name (If not institution, ga					4b. City, Tow					4c.		y of Death		
	-			HARFORD MEMORIA 5. Social Security Number 6.	AL HOSPI		(In yrs. last	hirthday)	HAVRE If Under 1 Ye		GRA Under 2		8. Date of Bi	rth	H	ARFOR		r Foreign
	П	Funeral Director		218-40-7644	1 □ M 2 💢 F		68	Yrs.	Months Da		Hours	Min.	JAN. 1	ay, Year)	943	PENN	lace (State o try) SYLVAN	TA
				Usual Residence of Decedent									OTHER I		J 13			
		anylar ahow det	_	10a. State 10b. County			10c. City, T									1	0d. Inside Cit 1 ☐ Yes	
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12			Funeral Director	10e. Street and Number 523 RED TOAD ROA	AD				10f. Zip Cod		901					What Coun		
5		itams 23a	Iner	11. Marital Status	12. Was Dece	edent E	ver in U.S.	13. V	Vas Decedent Yes, specify (of Hisp	anic Orig Mexican	jin? (Spe	ecify Yes or No Rican, etc.)	0-		ce - Americ		
	36	72 hours after natural', or ita	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gir	2XXX	0		☐ Yes 250		Specify:	, , , , , , , , , , , , , , , , , , , ,	,,			fy: WHI		
	8	72 hours "natural",	ed b	15. Decedent's 8	Year or D	ates:	1	6a Deced	lent's Usual Oc	cupatio	nn			16h Ki	ind of B	lusiness/Inc	fustry	
	215	nin 72	plet	(Specify only highest g	rade completed) College (I-dor 5		(Give I	kind of work do OO NOT use re	one duri	ing most	of worki	ng				,	
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	Ind	be file tal Hy doth avant	Be	17. Father's Name (First, Middle, Las	<i>(t)</i>					18	3. Mothe	r's Name	(First, Middle	e, Maiden	Sumar	me)		
	yla	Men Men Marks Marks Marks	၉	HORACE WIGGINS									BREWEF					
=	Maryland 21215-0036	permit. Pages 1 end 2 should be filed within Department of Heelih and Mental Hygiene. Important: if itam 27 ia marked other than any injury or other traumatic avant, the Magnes.		19a. Informant's Name/Relationship DELBERT COLLINS					g Address <i>(Str</i> ED TOAD									
3	Je,	of Hee of Hee itam		20a. Method of Disposition			20b. Place	e of Dispos	sition (Name of	f place)	i p	EBRI	JARY	NOT I	cation	HAM,	wn, State	
_	altimore,	Page ment of ant: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		State	NOTTI	NGHA!	sition (Name of natory or other M. BAPTI ERY	(ST		, 20				VANIA		
	Balt	permit. Departimporti		21. Signature of Funeral Services	nsee			22.	Name and Ad	ddress						-		
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		Physician /Medical		disease or condition resulting in death)	a	OXI		BRK	11/2	11	SUR	7			_	ι	LNKNOL	UVI
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		be executed icien and burial-transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dug to	/a						1		CALEXAM	INER			
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NS	ന	ficate phys s the			d													
COUNT	Box 6	eath certific attending pl for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out										23d. Da	ate of delive	ry	
201	Ď.	it the death by the atte	Icla	in the past 12 months?	4□Pregn	ant at ti	Fetal death		Ectopic pregna Other (specify							onth		/ear
	P.O.	at the d by the stached	hys	9 Unknown	9□ Unkn													
		e di di	ρ	Part II. Other significant conditions	contributing to de	ath but	t not resultin	g in the un	derlying cause	given i	n Part I.					tribute to th	e cause of d	eath? Inknown
V	of Vital Records,	w requir been si should	Completed															
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R	tal	sician: The certificate har rector, page		25. Was case referred to medical	1						o Disas	of Dooth	1 Yes	-		1 🗆 Yes	2 No	
3	Ξ	ysicil is cer direct	To Be	examiner? 1 ∰ Yes — 2 ∰ No	Hospital:	npatien	t 2 ERV	Outpatient	3□ DOA				ne 5□Res		6 🗆 Ott	her (Snecifi	<i>(</i>)	
)	0	ng Ph tter th	L:uc	27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mont			b. Time of	28c. li	njury at Work?			28d. Describe				,	
3	Siol	Attending death. ctor: Aft y the fun	catlo	2 Accident investigation	on			,,			2 🗆 N	lo						
3	Division	ofter d efter d Direct S in by	Certification:	3 Suicide 6 Could not 4 Homicide determined	4 280. Place	of Injur ng, etc.	y - At home (Specify)	, farm, stre	et, factory, offi	ice			28f. Location (City or To	(Street an wn, State	nd Numi n)	ber or Rura	l Route Num	ber,
なって		To the Hospital or Atlandi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier Cartifying P	hysician: To the minar: On the band man	asis of e	examination	dge, death and/or inv	occurred at the	e time, ny opini	date and on, deat	l place, a	and due to the	cause(s) date and	and m d place,	anner as st	ated. the cause(s)
#		To the To the Comp	Me	29b. Signature and title of certifier	1.		0		29c. Lic	ense ni	ımber			29d. Dat	te signe	ed (Month,	Day, Year)	
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		10		30. Name and address of person who Dr. Khalid Puthaw					Print)			de G	race. 1	Marvi	land	1 210	78	
		Sta		31. Date filed (Month, Day, Year)	32. R	egistrar	's Signature					0		y -				
		Registr	ar	FEB 03	2011 /	- see	a d	9. 1	arked									

#234 Cecil

Please Type or Print in Black Indelible Int Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 0640 TERRY LIMIS CROPPER. SR 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisburg Wicomica Kegional Medical Center If Under 1 Year | If Under 24 hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funera! 1**№** M 2 🗆 F Months Hours Country) Director 225-06-2009 7.17) 05/03/62 Usual Residence of Decedent 28a-f show 10a State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No ACCOMACK OAK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8055 LANKFORD HWY 23416 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. ō \$ 1 Never Married 2 K Married If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify. "natural", Completed 3 Widowed 4 Divorced BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) POULTRY SUPERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or and in ၉ UNKNOWN SHIRLEY CROPPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE CROPPER -8055 LANKFORD HMY. OAK HALL, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State FRIENDSHIP UM CEM. 4 ☐ Donation 5 ☐ Other (Specify) 02/05/11 WATTSVILLE. ice Cicensee 21. Signature of Fun-22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the dis nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical attending ph for use as the IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death signed by the a 9 Unknown Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 2 N Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 💢 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural work?
1 Yes 2 No 5 \square Pending iniury 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical ★Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print) Carroll State Registrar

Baltimore, Maryland 21215-0036

68760

Box

Records,

Vital

of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°11 7:30 P Jan Robert Connors Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundle Crofton Rehab Center Crofton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 25 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Months Min. Hours Massachusetts Director 942 030-30-9451 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8531 Ridgeline Terrace 20603 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) vas Decedent Ever in U.S.
irmed Forces?

\text{X} Yes 2 \sum No \text{Nat.}
Yes. Give 12. Was Decedent Ever in U.S 14. Race - American Indian, Black White etc. 0 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates.Guard Specify "natural", 3 Divorced 4 Divorced Completed White other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 4+ Retail Manager other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Frank Henry Connors Ruth Brutnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> f Health a Linda Connors/ Wife 8531 Ridgeline Terrace Waldorf, MD. 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Huntt Crematory 2, 2011 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 M81190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between spiration Immediate Cause (Final PREUMONIA Physician/ O days disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-tr Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract Infection 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Records, 1 Yes 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 25. Was case referred to medical examiner? To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) **Division of Vital** Hospital ျှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending death. within 24 hours after death

To the Funeral Director, completed filled in by the f Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Defense they, crofton, MO 21114 Name and address of person who completes cause of death (Item 23a) (Type, Print) 2225 av

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward Albert Densmore, Jr. 2:40 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Min 026-26-4133 Boston, MA 74 Director Yrs. August Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's Lanham 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6900 Lamont Drive 20706 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married X Yes 2 No Yes, Give 105 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced Year or Dates.1958-1968 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's may injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic and injures. Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Certified Public Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Albert Densmore, Sr. Grace Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary H. Densmore / Wife 6900 Lamont Drive, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lakemont Memorial
Gardens Cemetery 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2/3/2011 Davidsonville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Fogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Saque tially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed Yes 2 After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pendina 2 No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Destifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 201 D64268 of person who completed cause of death (Item 23a) (Type, Print) ROYCE 8118 BURNS, MD 6000 LUCK ROAD LAHHAM MD 31. Date filed (Month Pegistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Downes Eileen Armstrong 0704 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 12210 Cross Road Brandywine Trail 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 - M 2 XX Months Days Hours Min. January 8, Jelloway, Ohio 89 **Director** 577- 24- 0920 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director Maryland Prince George's Brandywine 1 Tes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral 23a USA 20613 12210 Cross Road Trail "natural", or items 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 VYYes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. White Completed 3 XXWidowed 4 ☐ Divorced 1945 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Space Management Expert Space Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Poland Laura Lucille Clarence Edward Armstrong permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandywine, MD 20613 12210 Cross Road Trail, Annette Duley - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastview Cemetery Feb. 11,2011 Centerburg, Ohio Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Approximate e on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy ρ in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown q Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 2 M No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 042509

State Registrar WFIND (22)

31. Date filed (Month, Day, Year)

76010

12070

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ms

32. Fegistrar's Signatu

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4	/Medic	al	Gail Maria 4a. Facility Name (If not institution, give street and number)	Daly-S	Sie	gelstein 4b. City, Town, or Lo	ocation of Death	January	_	2011 County of Death	0425	A M
	Examin	er	Meritus Medical Center		ĺ	Hagersto				lashingto	on	
	Funeral			(In yrs. last birthd		If Under 1 Year I	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Cour	place (State	or Foreign
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	/land			10c. City, Town or	r Loc	ation				1	Od. Inside (City Limits
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	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citiz	zen of What Cour	itry?	
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20	be filed within 72 hours after death with the Marylan at Hygiene. of other than "natural", or items 23a or 28a-f show event, the Modical Examinat must be rollified at	by Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 No. If Yes, Give)		Vas Decedent of Hisp Yes, specify Cuban, ☐Yes 2 X No	Mexican, Puerto Specify:	Rican, etc.)		Black, White,		
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2	and 2 s ealth ar n 27 ls ner trau		Marina J. Daly/Mother			Patterson		,	,		_ ′	
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	<u>~</u> □ = ē ō		23a. Part 1. Enter the disease, or complication that caused it shock, or heart failure. List only one carse on each line			01 Pennsy1				town, MD	Approxima Interval Be Onset and	ate etween
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0.00	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as to	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	QLI .		2	3d. Date of delive Month	ery Day	Year			
, can	iires that signed b d be deta	by P	Part II. Other significant conditions contributing to death but CARD 10 MY 0 PATITY		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown							
000	law requir	Completed	CHRONIC VEGETATIVE STA	TE				24a. Was an autopsy	as an 24b. Were autopsy findings available			
5	Physician; The le trithis certificate har all director, page 2		DIABETES MELLITUS	-					⊠No	death? 1 ☐ Yes	2□No	
•	Attending Physician: rr death, ector: After this certifica by the funeral director, p	Be	25. Was case referred to medical examiner? 1 ≥ Yes 2 □ No Hospital: 1 □ Inpatien:	t 2 🔀 ER/Outpa	tient	Othori		n <i>(Check only one)</i> me 5		Other (Specif	6.1	
5	Ph (0 (0)	n: To	27. Manner of Death 28a. Date of Injury	28b. Time	e of	28c. Injury at Work?		28d. Describe how		- , ,	<u>y)</u>	
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	al or Att after de I Directo d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, (Specify)	stre	et, factory, office		28f. Location (Stre City or Town,	eet and State)	Number or Rura	d Route Nu	mber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	edical C	29a. Certifier (Check only one) 1 Scertifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/o	eath r inv	occurred at the time, estigation, in my opin	, date and place, nion, death occurr	and due to the cared at the time, dar	use(s) te and	and manner as s place, and due to	stated. the cause	e(s)
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	NE		▶ MD			D006	2895	F	EBR	RUARY, O	1,201	11
	1		30. Name and address of person who completed cause of dea			,				~		
	Stat	0	PANLINE DALEY RICHARDS ND 1500 31. Date filed (Month, Day, Year) 32. Fegistrar	s Signature			. HAGER	2.10MN (MD	217	42	
	Registra		FEB 0 3 2011 Among	J. A.	100	while						

ME Workhuyber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ January 10:40 PM 2011 Barbara Ann Davis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center <u>Hagerstown</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🛛 F (Month, Day, Year, 71 Director 577-70-6349 July 19 Washington, D.C. 1939 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 310 Cameo Dr ural", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Year or Dates it of Health and Mental Hygiene.
If item 27 is marked other than "natus or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Antique Shop Owner Antique Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Geroge Walden Davis Alice Neale I and 2 should b I Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 N. Potomac St., Hagerstown, MD 21740 Bryan K. Kenworthy/Funeral Dir. permit. Page 1 and 5 Department of Health Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 4, 2011 Brentwood, Maryland Signature of Funeral Service Licens e 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Anopic ₹nysician/ En Certelo disease or condition Medical resulting in death) Due to (or as a consequence of ^{*}Examiner Le Mue In order Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Disc to IN as a consecuence of the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) To the Funeral Director: After this certificate has been signed by the atternor to the Funeral Director: After this certificate has been signed by the atternorm of the Funeral director, page 2 should be detached for in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 2 No 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes မြ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46561 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9401 MUNIOUN MD V1-2 (E3WOO) 31. Date filed (Month, Day, gistrar's Signature State Registrar

State Registrar 31. Date filed (Month, Day, Year)

FEB-2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gwendolyn Olivia Dennis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Nurs.& Rehab Center Wicomico Salisbury, 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day March 14 **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Months Hours . 19<u>26</u> **Director** 218-16-9310 84 Country) Maryland Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f 1 Yes 2 X No MD Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 26561 Collins Wharf Road 21822 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: Black "natural", Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any injury or other trainmatic marks. life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within College (1-4 or 5+) Supervison Salisbury University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Randolph Polk Helen Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26561 Collins Wharf Road - Eden, Maryland 21822 Brenda O. Dennis/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Friendship UMC Cem. 02/05/2011 Allen, Maryland 21. Sign Jury of Funeral Service License 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) co Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see or in. Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 \square Yes 2 \square No Day Pregnant at time of death Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 - No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident within 24 hours are co.

To the Funeral Director. Aft 5 Pending work 1 🗌 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

William |

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EUANS Month 11:15 AM 2011 Jan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Finksburg Carroll 2360 Sandymount Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) **1**∑ M 2 □ F Hours Marroh Do. Year 920 90 Mary Land **Director** 215-18-1406 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Carroll Finksburg 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2360 Sandymount Road 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. and 2 should be filed within 72 hours after deat Health and Mental Hygiene. tem 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced WII Specify: Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Congoleum Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Evans Blanche Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Evans/wife 2360 Sandymount Road, Finksburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of ₽ 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Carroll Cremation Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel M 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of diring, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Parks disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a cor Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown ate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe s after death. al Director. After this certificate ha 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert \$8915 2 W510+ 30. Name and address of person who comple of death (Item 23a) (Type, Print) STONER AUE WEST HINSTER 21177 REIJI 295

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Margaret Ellen Edgar 6:10P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Grantsville Goodwill Ret. Community 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 □ M 2 💢 F Months Hours (Month, Day, Year) Maryland Director 265-42-7756 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Garrett Oakland MD 1 ☐ Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 U.S.A. 5459 Hutton RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Board of Ed. Cook injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. 7 is mark ပ Belle Lewis Wagner, Sr. Daisy Claude Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health ar Important: If item 27 is any injury or any 164 Fingerboard RD., Oakland, MD 21550 Otto/ Daughter <u>Karen S.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrette de ma Count tryace) 2/4/2011 Oakland, Maryland Gardens 21. Signature of Fulleral Service Ligensee 22. Name and Address of Facility Newman Funeral Homes P.A. Second St., Oakland, MD 21550 203 s. 23a. Part 1. Enter the disease, or comp of ns wat caused shock, or heart failure. List only one cause on each line. ns Wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pivatory disease or condition resulting in death) Medical Examiner umonia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown signed by the a 9 Unknown P.O. Part JI, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 autopsy 2 XI No Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, I 25. Was case referred to medica Be Division of Vital 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and ti-29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. RODIN BISSON
31. Date filed (Month, PER Bar) 3 2011 Miller Grantsville, 124 MD 21536

State Registrar 32. Registrar's Signature

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			State of N	/laryland / De	partment of	Health and N	Mental Hy	giene	014.97
		_	Registrar 1. Decedent's Name (First, Middle, Last)	C	ertificate of	Death		Reg. No.	1 0 4 4 7 1
ı	Physicia		Doris Koenig Ehrenb	era			2. Date of De Month	Day Ye	
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79.00	4		Baltimore Washington Medic	al Center	Glen B			Anne Ai	
	Funeral Director		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthda 73 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	, , ,			Dec. 2	3, 1937 r	l'exas
	e filed within 72 hours after death with the Maryland tall Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County Anne Arundel	10c. City, Town or	^{Location} Yerna Park				10d. Inside City Limits 1 ☐ Yes 2X No
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003	ırs afte ural", il Exar	ted t	3 ☐ Widowed 4 🔀 Divorced If Yes, Give Year or Dates.	4110	1 ☐ Yes 2 🎇 No	Specify:		Specify:	White
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Maryland	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Palmer E. Koenig				e (First, Middle, y Hamil	Maiden Surname) ton	
lary	2 should be file Ith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street	and Number or Rura	al Route Numbe	r, City or Town, State,	Zip Code)
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nor	age 1 ant of h		1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stat	20b. Place of Dis e Hillcres	position (Name of rematory or other place E Memoria	ř Febr	uary 5,	20c. Location - City Annapoli	
Baltimore,	permit. Page 1 s Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee		Gardens		2011 1		<u> </u>
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	ed nsit	Examine	Sequentially list conditions, if any leading to in mediat cause. Enter Underlying Cause (Disease or iinjury	is consequence by					-1
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ita	sician: The certificate rector, pag	00	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Oth	ace of Death (Check	only one)		
of V	ding Phys th. After this funeral di	e: 10	27. Manner of Death 28a. Date of inju		ent 3 L DOA	4 U Nursing Ho	_	ence 6 Other (Sp ow injury occurred	ecify)
on	ending eath. or: Afte	ficat	1 Natural 5 Pending (Month, De 2 Accident Investigation 3 Suicide 6 Could not be	y, Year) injury	work	? Yes 2 🗆 No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Certificate:	4 Homicide determined 28e. Place of In	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Town	treet and Number or i n, State)	Rural Route Number,
L	Hospita 24 hours Funeral eted fillec	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of	my knowledge, death	occured at the time	date and place, and	d due to the cau	use(s) and manner as	stated.
	To the H within 24 To the F complet	Me	only one) 3 Certifying Nurse Practioner: To the	best of my knowledge	, death occurred at the	e time, date and place	e, and due to the	cause(s) and manner	as stated.
	7 ≥ 7 0		1 cll		29c. License	1471-	✓ *	29d. Date signed (Mo	nth, Day, Year)
7	11.00	ŀ	30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print) Will	am D	966	, ,	•
(1	H20		277 Peninsula / 31. Date filed (Month. Day, Year) 32 Benist	ar's Signature	1 ARI	VOLD	MU	21012	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) FEB 0 1 2011 32. Regist	neva A.	Sarke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Sophia Eckert Month ^{Year} 201 4:30p M Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 □**X**F Months Hours Min **Director** 92 216-18-9377 3/8/1918 MD Usual Residence of Decedent 28a-f shov hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Hampstead 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4422 Black Rock Road, Apt. 21074 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 \square Never Married 2 \square Married Black, White, etc þ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: white Completed 3 Widowed 4 Divorced Specify: Year or Dates al Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sewing machine operator sewing factory Be 17. Father's Name (First, Middle, Last) Should be file and Mental F 18. Mother's Name (First, Middle, Maiden Surname) Frederick Harmony other traumatic Rosie Louella Hite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Ebert H. Harmony, brother 3039 Arizona Ave., Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury or Poplar Grove Cem. 1/31/2011 Phoenix, Md. 21. Signature of Funeral Service License M00741 22. Name and Address of Facility Eline Funeral Home Mai Hampstead, Md 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician, Onset and Death End stage sepsis disease or condition Medical 1/21-1/27/2011 resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day Year Yes 2 ₩ No cate has been signed by the page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Tes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available autopsy performed? Yes 2X No prior to completion of cause of death?

1 Yes 2 No After this certificate B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Dove House 1 ☐ Yes 2 🙀 No ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide the Funeral Director: Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Certining Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Dearling in Nurse Practioner: To the best of my knowledge, death occurred at the time, determined at the time date and place, and due to the equation of the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tit e of c 29d. Date signed (Month, Day, Year) 2/2/11 DOOG 7468 30. Name and add person who completed cause of death (Item 23a) (Type, Print) 555 South Center Street, Westminster, MD 21157 nohit 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day, Year Month 42_M Medical Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death HOLY CROSS HOSPITAL MONGTOMERY SILVER SPRING Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) ULY 3 19 578-25-6594 Director JULY 1970 CAMÉROON Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD MONTGOMERY SILVER SPRING 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral 11546 FEBRUARY CIRCLE #201 20904 CAMEROON **Examiner must** items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Black, White etc. Completed by 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 2**X** No If Yes, Give 1 Yes 2 XNo Specify: Specify: BLACK "natural" 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 2YRS PHYSTCAL THERAPIST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည ALOYS JIMA CATHERINE NKWETA Page 1 and 2 should be f Health and Ment item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC ASSAH/BROTHER 11546 FEBRUARY CIRCLE #201 SILVER SPRING, MD 20904 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o ŏ 1 Burial 2 ☐ Cremation 3 ☐ Remo cemetery, crematory or other place 4 Donation 5 Other (Sc 2/12/2011 AMILY PLOT BAMENDA, CAMEROON Si un ture of Funeral Se J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease or complications caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of) Examine RESPIRATORY FAILURE Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Urknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🛛 No Yes 2 X N Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 X No ည 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident injury 5 Pending 1 Yes 2 No Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 🛮 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

only one

29b. Signature and title of certifier

KASHIF FIROZ M.D. 2101 MEDIAL PARK DRIVE SILVER SPRING, MARYLAND 20902 th, Day, Year)
FEB 0 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

date and place, and due to the cause(s) and manner as stat.

29d. Date signed (Month, Day, Year)

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 5:20 M Robert E. Forsythe, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2 / 7 / 1 9 2 9 **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Director 218-24-1461 Yrs. MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Westminster 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 3907 Littlestown Pike 21158 **USA** 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced white Completed Specify 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Forsythe Ethel Dayhoff t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 other 1 Mary Forsythe / wife 3907 Littlestown Pike. Westminster 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State Carroll Crematory 1/31/11 4 Donation 5 Other (Specify) Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kenworthy Funeral Home, Inc. Hanover, PA 17331 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. REBEA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 L 9 Unknown ate has been signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director. After this certificate is completed filled in by the funeral director, pag. perform 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniurv work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD038646-L WIL 28 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. ARUNULARAS AH, MS (OWEST KINK ST 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009